

**NO PLACE TO GROW UP:
HOW TO SAFELY REDUCE RELIANCE
ON FOSTER CARE GROUP HOMES**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FOURTEENTH CONGRESS
FIRST SESSION

MAY 19, 2015



Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

20-209—PDF

WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
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TUESDAY, MAY 19, 2015

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Chuck Grassley presiding.

Present: Senators Toomey, Wyden, Schumer, Stabenow, Bennet, Brown, and Casey.

Also present: Republican Staff: Becky Shipp, Health Policy Advisor. Democratic Staff: Laura Berntsen, Senior Advisor for Health and Human Services; and Jocelyn Moore, Deputy Staff Director.

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. The committee will come to order.

Today, the Senate Finance Committee will hear testimony on the need to reduce the reliance on foster care group homes. The basic premise of this hearing is very simple. Children should not be forced to grow up in an institution. It cannot be said enough that children fare better when with family.

Foster youth want the same thing as other children. They want a mom and a dad, and they want a place to call home. So we must do everything that we can to ensure that children, when placed in foster care, are given every opportunity to be normal and are nurtured and loved along the way.

I have worked for decades to ensure that every child gets to grow up in a safe and loving family. I was the principle drafter of a landmark act called Fostering Connections to Success and Increasing Adoptions. As founder and co-chair of the Senate Caucus on Foster Youth, I am deeply engaged in developing policies that will help all children find loving and forever families.

Group homes, sometimes referred to as congregate care, create conditions that make children and young people vulnerable to a number of negative outcomes, such as homelessness, incarceration, substance abuse, and poverty. Group homes are expensive. Some research indicates that they are up to 10 times more expensive than family-based homes. It calls into question then whether we should be paying for such placements when they are associated with negative outcomes. What also makes no sense is that in some

instances, if the proper services had been available, these young people could have remained safely at home and not needed to go into foster care in the first place.

Some allege that children and young people in group homes have to be there because they cannot be safely placed in a family foster care setting. However, the data simply does not support that. A recent report from Health and Human Services reveals that, quote, "Children 12 and younger comprise an unexpectedly high percentage, 31 percent, of children who experience a congregate care setting."

According to HHS, 40 percent of children and youth in congregate care have no documented clinical or behavioral reason for a non-family placement. Many believe that infants, children, and young people with manageable behavior issues or no behavior issues should not be placed in congregate care facilities at all.

For youth who have severe mental health diagnoses, improvement can be made in a specialized setting for a limited period of time. However, there is no research whatsoever that a long-term placement in a therapeutic group home produces positive outcomes. In fact, we will hear today testimony that supports anecdotal evidence that concludes that, after a period of a few months, any progress made in a therapeutic facility is undone.

But the bottom line is this: children belong in a family. Families are where we find support and love and comfort that sustain us in challenging times.

Increasing placement with kin will also reduce the use of group homes. There are many benefits to kinship care. Placing young people with close relatives provides more stability, helps keep siblings together, and reduces the emotional trauma of being separated from their parents. Kinship placements also allow young people to maintain community, school, and family relationships. Children need someone to tuck them in at night and make them feel safe. Young people need positive adult role models to help them make the transition to adulthood.

So we need to do whatever we can to ensure that every child has a loving, safe, and permanent home. I hope that members will listen very carefully to the testimony of our witnesses and policy recommendations presented to us today.

It is now Senator Wyden's turn.

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Chairman Grassley. You and Senator Hatch, in my view, have been real leaders on this topic, and I am very grateful.

Obviously, Mr. Chairman, this morning I have to juggle the floor where we are working on the trade legislation, so I am not going to be able to stay throughout the morning.

I also want to note that several of my colleagues would like to make short statements. I know Senator Schumer has folks here from New York. So I would request at this time that our colleagues could make short statements.

As the title of this hearing suggests, foster care group homes are no place to grow up. There is no question that residential care can play a crucial role in the foster care system. There is wide consensus that children and youth, especially young children, are best served in a family setting.

Stays in residential care should be based on the child's specialized behavioral and mental health needs or a child's clinical disabilities. They should be used only for as long as necessary to stabilize the child or youth before returning to a family setting.

My view is, this theory is finally catching on. Over the last decade, States have cut by over one-third the number of children who reside in congregate care. There has been a wide variation in States' success in this area, with some even increasing their use of congregate care over the last decade.

To further reduce residential foster care, it is time to also focus this debate on transforming the old group home model into one that is considerably more flexible, more flexible to meet the needs of each child and family rather than forcing an inappropriate and ineffective one-size-fits-all approach.

The committee is going to hear today that this transformation is possible, and we are going to hear that it is possible even within the current lopsided funding system. The Federal Government can make innovation easier by providing greater flexibility in the use of title IV-E foster care funds—flexibility that accepts the reality that there is no single approach that works for every youngster and every family.

To spur these innovations, we ought to be looking for more fresh, creative ideas. That is why this hearing is so important and why we need to hear from today's witnesses about their experiences with congregate care. I am especially grateful to Associate Commissioner Chang for coming to discuss the administration's ideas for reducing the use of these settings.

I am going to wrap up by just making three observations on the topic. First, there is no question that high-quality residential care plays a crucial role in what is, in effect, a continuum of foster care services, but at the same time, it is clear that not everybody is on the same page when there is a discussion about congregate care. The terms "congregate care," "group homes," and "residential treatment" are often used interchangeably. The structure and quality of these settings, in reality, varies very widely, and we are going to hear about that from our witnesses today.

Second, it is important that the discussion over safely reducing congregate care commensurately focuses on building additional opportunities and the capacity for foster parents, kin, adoptive parents, and entire communities to care for kids in family settings.

Finally, the best way to reduce reliance on chronic care is to prevent children from entering foster care in the first place. For decades, lawmakers, advocates, and others have talked about the need to provide support and preventive services for children and families in crisis. These investments can help keep kids safe in their homes or with other family members, while reducing the need for costly and traumatic transfers to the foster care system.

For this reason, I have drafted legislation to reform foster care, to give States and tribes the ability to use Federal dollars that are

now reserved only for foster care placements to finance new opportunities to keep families together. We ought to be considering those fresh approaches, fresh ways of thinking about how we serve the goal that all Americans want here, and that is ensuring that kids grow up in a healthy and safe environment.

It is no understatement, Mr. Chairman, that families and kids are counting on this committee working together in a bipartisan way to get this right. I look forward to working with you, Chairman Grassley, and Chairman Hatch. As I have indicated, both he and I are tied up also on the floor this morning. But this is a very important topic, and we look forward to working with our colleagues in a bipartisan way on it.

[The prepared statement of Senator Wyden appears in the appendix.]

Senator GRASSLEY. Senator Schumer?

**OPENING STATEMENT OF HON. CHARLES E. SCHUMER,
A U.S. SENATOR FROM NEW YORK**

Senator SCHUMER. Thank you, Mr. Chairman. I will be brief. I want to thank you for having this hearing. I want to welcome our witnesses and apologize. I will not be able to stay, with everything going on, but I have read their testimony, and it is superb.

I want to particularly welcome Matthew Reynell from Rochester, NY and Dr. Jeremy Kohomban from The Children's Village, which does a great job in New York City, my home city.

We all share the goal of trying to keep kids safe and keep them in families. Too often our kids enter the child welfare system, for various reasons, and in those cases, our goal should be to get them the services they need, reunify them with their family or place them with a kin family member, or place them in a loving, safe foster home.

The services that these kids need are sometimes at residential facilities. But more often than not, as The Children's Village in New York and Mr. Reynell have testified to, there are community-based services that allow a child to live or progress toward living with a family.

The Children's Village provides services to over 17,000 children and families each year. Some are at their residential treatment centers, but most are not. Mr. Reynell of the great city of Rochester, where I was yesterday, has also testified that his adopted son thrived at home with him, but also needed the services that Crestwood Children's Center provided him.

Being a parent is a gift, but also a challenge. All families have difficulties. All children need help sometimes. And the love and commitment that you have shown by not only adopting your son, but insisting and ensuring he receive his needed services, is what we are all about and why we are here today to try to improve the system.

We need to support other individuals and families who want help and get children into healthy and loving environments. The experiences of these New Yorkers, Mr. Chairman, provide proof that every child is different and will need different services. As the ranking member has said, the only way to truly help our children is to allow States and localities to have flexibility to spend Federal

foster care money on what works best for their kids, from prevention to residential care to support for foster families.

In New York, about 10,000 kids enter foster care each year, but 200,000 kids are being investigated as at-risk. With a Federal waiver, New York City has built upon work from the last 20 years to do just what we need. The city, like many other jurisdictions, has drastically reduced the need and use of foster care. New York's foster care numbers have shrunk from a high of 45,000 children in 1993 to 11,000 in 2014. If there was ever a testament that flexibility works, that is it.

This has happened through a focus on family preservation, expediting permanent placements through reunification, adoption, and guardianship. Currently, New York City has reduced the use of congregate care, the group homes, from 5,000 to 1,000 children in the past 15 years, as we recognize the importance of placing young people in supportive family settings wherever possible, including with relatives or in kinship care. And, under the Federal waiver that it operates under, New York now has additional resources to focus on permanent placements and the well-being of children.

So, Mr. Chairman, we need to help States find what works for them and their children. The waivers and our witnesses have shown us that flexibility in Federal funding is an important step to ensuring that our children remain or end up with a loving family.

Thank you.

Senator GRASSLEY. Senator Stabenow?

**OPENING STATEMENT OF HON. DEBBIE STABENOW,
A U.S. SENATOR FROM MICHIGAN**

Senator STABENOW. Thank you, Mr. Chairman, for holding this meeting. It is my pleasure to serve with you as co-chair of the bipartisan Foster Youth Caucus. I will wait to speak more specifically later so we can hear from our witnesses, but I just share in your comments and those of Senator Wyden and Senator Schumer about the importance of this.

I was very pleased years ago to be involved in authoring foster care reform in Michigan, and we continue to need to focus on children and the opportunity for giving them safe, loving homes.

So I look forward to hearing from the witnesses.

Senator GRASSLEY. I thank each of the people for their opening statements, and particularly the ranking member, Senator Wyden.

So now to introduce—and we will have people testify in the order in which I introduce you. First, we will hear from Ms. Lexie Gruber, a former foster youth. We congratulate you on graduating with honors and for your job with First Focus.

Dr. Jeremy Kohomban is president and chief executive officer of The Children's Village in New York, and I guess you could not have a better introduction than Senator Schumer gave to you.

Matthew Reynell is an adoptive father of two children who will share his personal experiences. Thank you for that.

Finally, Associate Commissioner Joo Yeun Chang is with the Children's Bureau at the Administration for Children, Youth, and Families.

I welcome all of you to the Senate Finance Committee. As you have probably been told by staff, you have 5 minutes, but if you have a longer statement, it will be put in the record as well.

So, would you proceed, Ms. Gruber?

**STATEMENT OF LEXIE GRUBER, FORMER FOSTER YOUTH,
HAMDEN, CT**

Ms. GRUBER. Good morning and thank you, Chairman Grassley, Ranking Member Wyden, and members of the committee, for the invitation to be here today. I am so humbled and thankful for the opportunity to share with you my experiences in a foster care group home.

My written testimony details how I came to be placed in a group home setting, and, for the purposes of my oral testimony, I will focus on my experiences in a foster care group home.

Shortly after I turned 17, the Connecticut Department of Children and Families decided to find a group home placement for me because there simply was not anywhere else for me to go. I was a great kid, but there were not many homes for someone my age. And DCF also felt that my anxiety and depression made me a poor fit for a family.

When I entered the group home, I was informed that they would try to find me a family if I improved my behavior, as if my stay in the group home was a trial for me to prove that I was worthy of being loved.

The group home I was placed in looked more like a business than a home. The walls were adorned with informational posters like those in doctor's offices rather than the familial photos that line the walls of my friends' houses. Outside the staff office on the second floor hung a whiteboard where the staff wrote down information, such as what was for dinner, instead of informing us of these things in person.

Health regulations prevented residents from preparing their own food or entering the fridge without gloves, and the cabinets were locked to prevent us from stealing food when the budget limited the availability of snacks. Within the group home, there was a disciplinary system known as a "level system," which was more militant than familial. It was a punitive system that granted us age-appropriate privileges as long as we maintained the most absolutely perfect behavior.

When you first entered the home, you were on individual phase. You got 30 minutes on the computer and one phone call to someone outside of your family. Eventually, you could work your way up to the third phase, known as community phase, if you maintained absolutely perfect behavior for an incredible amount of time.

On community phase, you could go for an hour walk by yourself. One of my fondest memories of high school was being able to walk to the local corner store and buy my favorite bag of chips with the meager allowance that I earned. However, these few privileges could be taken away in a single second. Any bad behavior, such as swearing, meant that you had every privilege taken away, no sacred home passes with your biological family and none of those few precious moments outside by yourself.

These privileges were the only thing that kept me sane, and I felt constantly on edge, afraid that my lifeline would be taken away at any moment. I could not understand why I had to act perfectly just to have the basic social privileges of a child. Why was I being penalized for having been removed from an abusive home? I felt like a wrongly accused offender locked away for someone else's crime.

The group home was staffed in rotating shifts. The staff were often tired and on edge due to being overworked and underpaid. They tried their best, but they were not supportive in their roles, and this was reflected in their interactions with residents.

They would often remind us that they only put up with us for the paycheck. Additionally, the staff were not allowed to show any physical or emotional affection. During my entire year and a half in the group home, I was only told "I love you" one time, and it was in secret.

The normalization of being cared for in exchange for profit and deprivation of affection led some residents to engage in sex trafficking. The group home staffs were also ill-equipped to handle the symptoms of my post-traumatic stress disorder. They saw my erratic, depressed behavior as acting out, when in reality I was a traumatized child trying to make sense of an incredibly irrational situation.

I was also forced to take a myriad of medication. Every week, residents of the group home had to attend a mandatory meeting with a psychiatrist. If we skipped this meeting, we lost all our privileges, and we attended out of fear.

The doctor prescribed me a pill for every emotion I was experiencing. If I was moody during our visit, he would give me a new prescription and claim that my behavior was due to mental illness rather than seeing moodiness as a normal teenage response to being forced to see a doctor.

Although I desperately wanted and needed a family, there was no effort to find me one. They never found me a family after spending a year and a half in the group home, and I left to attend college. My transition to the dorm room was incredibly difficult, as I had no dedicated adults to support me as I struggled to acclimate to a college campus.

It has been 4 years since I left the group home, and my life is so much better now. Two days ago, I graduated magna cum laude from Quinnipiac University, and I am moving to DC soon for a job at First Focus.

I have completed rigorous treatment for my post-traumatic stress disorder. I am now able to enjoy the sweetness of every single moment of my incredible life.

It is still difficult for me to talk about my experiences. To be truthful, I would rather put it behind me and just enjoy the fact that my life is better now. But I will never do that and I cannot do that, because I need to ensure that no other innocent child endures what I endured.

Again, I want to thank the committee for the opportunity to testify and share my story, and I am happy to answer any of your questions.

[The prepared statement of Ms. Gruber appears in the appendix.]

Senator GRASSLEY. Thank you very much.
Dr. Kohomban? Go ahead, please.

**STATEMENT OF JEREMY KOHOMBAN, Ph.D., PRESIDENT AND
CHIEF EXECUTIVE OFFICER, THE CHILDREN'S VILLAGE,
NEW YORK, NY**

Dr. KOHOMBAN. Good morning, Chairman Grassley, Ranking Member Wyden, Senators. Thank you for the opportunity.

I am Jeremy Kohomban. I am the president and CEO of The Children's Village and our affiliates, Harlem Dowling and Inwood House. Founded in 1851, The Children's Village has been home to some of the earliest examples of residential programs in the Nation. Today our organizations serve more than 17,000 children and families each year.

We remain one of the largest residential treatment centers in the Nation, serving older teens, pregnant teens, teen mothers with children, girls who are trafficked, and even children adjudicated for sexual offenses.

Effective residential care is very difficult to do. It is tough work. We are strong proponents of effective and responsive residential care. However, residential care is simply the wrong intervention for most children, including teens, a conclusion that the Annie E. Casey Foundation documents in their commendable policy report that was released today.

Until a decade ago, our primary prescription was to remove and treat children away from families and neighborhoods that were considered bad. We followed the best practices of the time. We had the very best of intentions.

While we sought to help, often we did not. Our practices, like the practices of child welfare nationwide, managed to do the opposite of what was intended. Children and families became system-dependent. They never learned how to belong to each other and to act as family with the necessary give, take, and tolerance for one another's successes and shortcomings.

In many cases, our children were aging out and returning to the same imperfect families that we kept them away from. They did so because they had no other place to go. Others drifted in and out of homelessness, disconnected from society, in frequent contact with the criminal justice system.

Many say that the children in residential care are mentally ill. That is not true. The majority are children in pain, children born into poverty, and today they are children who are black and increasingly brown.

Some will tell you that we cannot find kin or foster families to care for these children, especially to care for teens. I disagree. It is not easy, but we do it every day. A decade ago, The Children's Village had fewer than 50 foster families. Today, we have almost 400, many who serve teenagers in their homes.

Changing the perverse incentives of the current funding methodology will help. When residential providers get paid by the day for each child, we are forced into business models that require keeping kids in beds rather than meeting kids' needs and helping them live with family. What is best for our Nation's children should no longer remain hostage to an archaic funding formula.

The caution here: to safely reduce residential care, there has to be a substantial and sustained reinvestment in effective community services into the poor, economically disadvantaged, and the increasingly racially segregated communities where most child welfare children come from.

A few weeks ago, a teen at our residential treatment center said this to me. He said, "I'm smart. I have been here for 6 months. My mom is a drinker. She chose not to get help. There were lots of drugs, bad money, and bad people in my house. My dad is in jail. I don't have contact with him. The Department of Social Services put my four younger brothers in different placements. I have been in many foster homes. They kept moving me. Finally, they sent me to The Children's Village. Sometimes I visit my brothers, but I never see my mother. Who do I trust? Not a lot of people. I come from a home where my mom beat me, but then she was beaten, too. Nobody visits me here; nobody. When I graduate, I am going to move down to Florida. There is a family friend down there. I am going to attend a big university that will take me, like Florida State, Jacksonville, or Daytona."

Mr. Chairman, I get it. There are no easy answers. Each time I hear stories like this, it breaks my heart. I do not want to see this boy suffer anymore. I want to keep him forever, but he can never truly belong at The Children's Village. No child does. They must all leave.

We cannot undo his terrible past, but together we can help him build new memories. If we fail him, the chances are that he will recreate his experience with his own children, and he will be unprepared to participate in our great democracy. He will be disconnected.

He deserves to know love. He deserves to belong to someone. He deserves to be with someone who believes in him, someone who helps him reach his American dream. He deserves nothing less than what my own children, Nicholas, Jordan, and Abigail, take for granted every day—the experience of unconditional love, family, and belonging.

I know we can do this.

[The prepared statement of Dr. Kohomban appears in the appendix.]

Senator GRASSLEY. Thank you.

Mr. Reynell?

**STATEMENT OF MATTHEW J. REYNELL, ADOPTIVE FATHER,
ROCHESTER, NY**

Mr. REYNELL. Chairman Grassley, Ranking Member Wyden, and all the members of the Senate Finance Committee, thank you for inviting me to testify today on this important topic to highlight the ways to safely reduce the over-reliance on group homes and congregate care.

My name is Matthew Reynell. I am from Rochester, NY. I am excited to tell you about my family's story of adoption through the residential treatment facility where my son was placed.

I met my son, James, on December 31, 2008, thanks to the help of a diligent representative at Children Awaiting Parents in Hillside who was able to locate him and convince the worker to take

a shot. He had just turned 8 years old and was living at Crestwood Children's Center. James had been brought into the foster care system 4 years earlier with his siblings. Prior to residing at Crestwood, James had been moved around to several foster homes and schools. The foster parents at his last home had given him the promise of adoption of all the children together, but later decided that James was too much for them to handle and had him removed. This is how James came to Crestwood.

I have always believed that no matter what reason, children should not end up in group homes or congregate care facilities. I viewed these places as awful, where problem children were dumped and then forgotten about.

After learning that James resided at Crestwood, I became very upset and thought I needed to get him out of there as soon as possible. Going through the process of getting to know James through his case workers and treatment team, my attitude and beliefs about this awful place were changing.

James had been severely neglected and received minimal schooling prior to arriving at Crestwood Children's Center. He could not read or write at age 8. James was a child who had always been labeled the problem kid, the kid who did not listen like the others, the kid who did not do his school work like the others. He had a history of outbursts that made people think of him as uncontrollable.

As a child, not only did James have a difficult and grim history with many of the foundations of early childhood development absent in his young life, he was born with fetal alcohol syndrome and suffered severe neglect mentally, physically, and educationally.

When he arrived at Crestwood, a treatment consisting of therapists, psychologists, clinicians, doctors, teachers, and occupational therapists was assigned to him. I learned to view these dedicated individuals as part of James' extended family and discovered the vital role that this team would play in our lives.

However, I cannot help but think where James would be today if we did not find him, if he did not find us. The care and attention he received from the amazing people at Crestwood were crucial to his success in moving forward. Through his heartbreak and tragic home life that caused him to mistrust and fear his surroundings, as well as the individuals who cared for him, he could now truly open his heart and accept that he was going to be part of a family.

I spent 5 months visiting James while he was at Crestwood and worked closely with our team. James received the attention he both needed and deserved. He was able to start reading and writing and functioning in a home environment and, most importantly, dealing with all of his past traumas.

Through my experiences with Crestwood, it is my belief that there needs to be a set time frame for children to reside in a treatment facility. Please, if you take anything away from what I have shared thus far, understand that I think Crestwood is the exception in regards to what youth experience in congregate or residential care.

If a child needs to be in a group home placement, the team and case workers should always be working to identify a permanent resource for that child, whether it be kinship care, an adoptive fam-

ily, or a permanent foster home. Facilities should be required to have family inclusion policies. They should not be solely focused on the emotional and behavioral issues. These are breeding grounds for failure because these children have no identified exit strategy.

Some people believe that treatment must be sustained and then permanency found, but in my experience, youth need to feel loved and protected by the people who care about them before they can start healing their hearts. In my case, I had known James for 5 out of the 10 months he had been living at Crestwood, and he had made tremendous progress both mentally and socially during this time. However, when I asked to move him home, the staff kept putting it off out of fear that it would not take. James then regressed back into old behaviors thinking that we are not going to take him back to our home.

After moving into our home, James and I were still able to keep the same team through Crestwood Children's Center. James is now 14 years old, thriving, reading and writing at school level, and all of this, I believe, is because of the love of a family.

Our aim and dream for all children in the foster care system should always be to find the child a loving, secure, and forever family. Now, having gone through this process, I understand and believe that to reach this goal may require an intervention of a residential treatment facility and the services they can provide to both the child and the adoptive parent.

We need to have the group home staff, counties and others involved with the child, and the case workers collectively working toward the goal of a forever family, whatever that may be. I believe residential treatment is something that is sometimes needed for children, but we cannot get the outcomes we desire if they are set up to only treat the child and not include and support the parents or other caretakers the child is going to move in with.

I will conclude with remembering a conversation that James and I frequently had in the car when we would take our day trips to know each other. We would sing along to songs that were popular on the radio and we would get laughing at the end, and I would say to James, "You are a silly boy. What am I going to do with you?" James would reply in a slightly serious tone, "Keep me, please, daddy. Keep me." I did, and that decision is the best decision I ever made.

Thank you very much for your time.

[The prepared statement of Mr. Reynell appears in the appendix.]

Senator GRASSLEY. Thank you.

Ms. Chang?

STATEMENT OF JOO YEUN CHANG, ASSOCIATE COMMISSIONER, CHILDREN'S BUREAU, ADMINISTRATION ON CHILDREN, YOUTH, AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. CHANG. Chairman Grassley, Ranking Member Wyden, and members of the committee, it is my pleasure to appear before you on behalf of the Department of Health and Human Services.

The administration believes that children are best served when raised in safe, loving families and that congregate care should be

limited to children who need intensive residential care due to medical issues, and only for as long as those interventions are needed. That is why the President's fiscal year 2016 budget includes a proposal to limit the use of congregate care by increased monitoring and by promoting supported family-based care.

We are grateful to you for having this hearing and bringing more attention to this issue.

My name is Joo Yeun Chang, and I am the Associate Commissioner of the Children's Bureau. In this role, I oversee the Federal foster care and adoption assistance programs, as well as a range of prevention and post-permanency initiatives.

At HHS, we work with State and tribal agencies that administer child welfare systems to ensure that vulnerable children in foster care are placed safely in the least restrictive, most family-like settings available and that are in the best interest of individual children.

In March of 2015, the Administration for Children and Families issued a data brief providing a national look at the use of congregate care in child welfare. The brief was developed to provide a basic understanding of the use of congregate care and to answer the following questions: who is placed in congregate care; how long do children stay in these placements; are there any predictive factors; and what, if any, are the jurisdictional differences in the use of congregate care?

To answer these questions, ACF conducted an analysis of State-reported data. We found that, on any given day, an estimated 14 percent of all children in foster care were in congregate care settings. We also found that children in congregate care are almost 6 times more likely to have a child behavior problem designation and 3 times more likely to have a DSM or mental health diagnosis compared to children in other settings. Most children in congregate care are in the setting for an average of 8 months, but those with a DSM diagnosis are most likely to stay in congregate care settings for more than 1 year.

In addition to this point-in-time data, which overly relies on children who have been in those settings for longer periods of time, we created a longitudinal cohort of children over a 5-year period of time to better and more fully understand the use of congregate care. We found that older children consistently represented a majority of those who experienced congregate care, and, among these youth, 44 percent had a child behavior problem as at least one reason for entry into foster care, 21 percent had a DSM or a mental health diagnosis, and 6 percent had a clinical disability other than a DSM diagnosis. We were troubled to find, however, that children with no clinical indicators comprised nearly 29 percent of children who experienced congregate care.

Overall results indicate that youth with a DSM diagnosis and a child behavior problem indicator were most likely to experience congregate care at some point. Children with a DSM diagnosis were more likely to have congregate care as a subsequent placement, have been previously adopted, and have three or more placement moves compared to other subgroups.

Children with a child behavior problem indicator were more likely to enter congregate care as their first placement, while in foster

care have only one or two placement moves, and then finally exit to a permanent home. However, I want to note that youth with a child behavior problem indicator were also more likely to reenter care after they left and to be transferred to another agency, like the juvenile justice system.

Based on the findings from the data brief and the insights we gained from States that have significantly decreased their use of congregate care, the administration developed a proposal in the President's budget to reduce the use of congregate care by significantly increasing the monitoring of congregate care use and promoting specialized family-based care. The administration's proposal for family-based care impacts any child who is in or at risk of being placed in a congregate care setting.

The proposal would amend title IV-E of the Social Security Act to provide additional supports and funding to promote specialized family-based care as an alternative to congregate care for children with behavioral and mental health needs and to provide oversight whenever congregate care placements are used, at both the initial placement and at 6-month intervals.

I very much appreciate the committee's interest in the issues raised today and the opportunity to speak with you. We look forward to working with you to address this crucial issue and to improve services for some of our most vulnerable young people.

Thank you.

[The prepared statement of Ms. Chang appears in the appendix.]

Senator GRASSLEY. Thanks to all the witnesses. I am going to start with Ms. Gruber, first of all, to thank you for coming to the committee and testifying and sharing your experiences. We have a lot to learn from such experiences.

To begin with, were you involved in determining which treatment options were available to you?

Ms. GRUBER. Thank you for your question, Mr. Chairman. My input was not taken into consideration. I also had other family members, like my uncle and other mentors, who tried to speak about what I needed, and their input was not taken as well.

Senator GRASSLEY. If it is valuable to the committee, I would like to have you describe any therapy or counseling that was available to you. But the most important thing is, if you do not think you need to describe it, do you feel that these interventions were helpful?

Ms. GRUBER. The therapy that we received in the home was focused on our behaviors and not our trauma. There was no connection between why are we acting out and do we understand where these behaviors come from.

There were no trauma-informed practices, and I think that was one thing that was really harmful. For example, a lot of the therapy I received in the home was about me surviving my present situation, and I often discussed how I wanted a family and how I did not feel like I was worthy of love because of my current situation.

So I was not even able to deal with the trauma that brought me into foster care until I was in college. And so I think that is one thing that we can learn from this: being more trauma-informed and focusing on the trauma rather than the behaviors.

Senator GRASSLEY. Thank you.

Mr. Reynell, thank you for appearing before the committee, but more importantly, for opening up your home for adopted children, and thank you very much for helping them and for what you do.

First question: do you agree that families who want to open their homes to children coming from more restrictive placements like a group home face a challenge as a child steps down to a less restrictive setting?

Mr. REYNELL. Thank you very much. I do, but if there is a carefully planned timeline of when that child steps down and what supports that you are going to have in place—our supports happened to be right through the residential facility where our son came from. And we, as the parents, were the driving, pushing force towards that, to get him home and say, we will deal with what comes next and use the tools and also the staff that they have in the treatment facility.

Senator GRASSLEY. Could you describe the challenges you faced with your son and the services and support that helped you manage his needs?

Mr. REYNELL. Definitely. James had severe PTSD when he came home. He also had fetal alcohol syndrome. He had about 7 homes within 4 years, being removed from, first, his biological mother and then being removed from his biological siblings.

James needed a lot of support in all areas: educationally, mentally, and physically. We arranged that the Crestwood Children's Center would provide us with outpatient care to provide him still with his educational resources, psychology resources, as well as occupational therapy resources.

The moneys that we received on behalf of James also all went to James's care. We got him tutors as well as an outside therapist to come in and work with us in the home.

Senator GRASSLEY. Ms. Chang, how can we help ensure that more children are placed with kin instead of relying on group care?

Ms. CHANG. Thank you, Mr. Chairman. That is a great question. I think kin are often underutilized and tend to be the type of providers who will provide stable homes, particularly for children with social and emotional needs.

One of the things that was really interesting that we found in our research was that, even though children with child behavior problems or a mental health diagnosis tended to go into congregate care, that percentage decreased when kids were initially placed with relatives.

And what we found is, it is pretty intuitive. Relatives are more likely to fight harder, to get therapies, and put up with things that they may not understand or initially know how to deal with. And so I think relatives can be a crucial partner with us in helping keep kids out of congregate care.

With that said, they do sometimes need additional supports. They may need specialized help from the case worker who actually understands the social and emotional needs of that child, who has more time to give to that family, and they may need additional support—perhaps the child needs day treatment.

And so that is one of the reasons why we would support an effort to allow IV-E payments to be used to provide additional supports

to bolster that family so that the child can remain in the home and not go into congregate care.

Senator GRASSLEY. I am going to call on Senator Wyden.

Senator WYDEN. Thank you very much, Mr. Chairman. All of you have been great. Ms. Gruber, your testimony was so powerful. And what I want to explore with you a little bit more is how we can tap the extraordinary untapped potential of kin, because I think that this is an area where—and I am just going to take a minute to give you a bit of the history.

Back in the middle 1990s, you might recall, there was a lot of discussion about orphanages, and that was all over the news. Newt Gingrich said we were going to have to put kids in orphanages. And I pointed out at that time that not every one of those orphanages is Boys Town and that was something that we ought to think about, and I managed to get passed a law called the Kinship Care Act.

What it basically said was, aunts and uncles would have first preference in terms of caring for a youngster, a grandchild, niece or nephew, as long as they met the child custody standards.

It seemed that things were getting a little bit better for a while. We actually had a formal Federal law. It was the first Federal law—Ms. Chang remembers this—the Kinship Care Act, and it was passed in the middle or late 1990s.

What I was struck by is—and I want to make sure everybody gets to hear this, because I do not think it was part of your verbal testimony—here we had a situation where you felt that your uncle clearly could meet the child custody standards. He basically was not allowed to because he was short one bedroom, and the social worker, the staffer, I think you said, could have gotten a waiver, but basically just did not bother to go out and get the waiver.

Is that a fair statement of what happened?

Ms. GRUBER. That is an incredibly accurate story about what happened. I was placed with my Uncle Chris and Aunt Karen, who were very involved with my church. I was still able to be part of that community, which was very important to me, and they fought to keep me in their home, but because he had one fewer bedroom—and there could have been things done.

There could have been a waiver passed, working with us, but it was not done. And my uncle continually reached out to the Department and said, “She needs to stay here.”

I was also with my sister. And when he reached out to them, they basically said, no, stonewall up, we are not going to work with you. And from my interpretation of that, it was because it would have been more work.

Senator WYDEN. It would have been more work for the bureaucracy.

Ms. GRUBER. Yes. And so the bureaucratic technicalities weighed more than permanency for me, and it was so important for me to live there, but they separated me and my sister. And they took me from my uncle’s home, and they dropped me off at a shelter.

So now I had gone from being removed from my biological family and my beloved dogs to being placed with my uncle, to being removed from him again, and now I was homeless, and I spent the

next 2 years bouncing between homeless shelters, group homes, and short-term placements.

Senator WYDEN. I want you to know that I am going to make sure, as we talk about this, that we are going to do this in a bipartisan way with Democrats and Republicans. This account that you have just given provides a real wakeup call to this committee, because this is something, colleagues, that should not have happened. It should not have happened.

It is clear that your uncle pulled out all the stops to prove that he could provide the kind of quality and healthy care that you needed, and yet basically the bureaucracy triumphed over common sense. That is essentially what happened in this case, and that is what we started trying to prevent back in the middle 1990s when we said, look, kin is the best place to go.

I had some particular involvement in it because, before I came to the Congress, I was director of a senior citizens group, and they said, we want to play a bigger role in this.

So I am going to wrap up. Ms. Chang, what are we going to do now to punch some flexibility into this so that the kinds of accounts that Ms. Gruber has given us go into the dustbin of history? Because this was a situation where an uncle could have ensured that this youngster had a healthy experience, and basically he got worn down by the bureaucracy and red tape that basically said, bureaucracy counts more than common sense.

What are we going to be able to do in this bill? And, as you know, I put out a draft that focuses primarily on flexibility, to make sure that Ms. Gruber's account basically goes into the dustbin of history and we have finally achieved what we thought we were doing in the 1990s, with a streamlined way to make sure that kin who could deliver quality care could have that opportunity. Response?

Ms. CHANG. Sure. I thank you for the question, Senator Wyden.

I appreciate your passion, and I think it is exactly this type of leadership and vision that we need to move the field in a different direction.

I think what happened to Lexie should never happen to any child. You are absolutely right that when a family member is available, we should do everything in our power to make sure that they can stay in their care and not get in the way of our own selves.

I think there are a couple of things that we can do. One, the draft bill, that discussion draft that you described, would be an incredibly important step in that direction. If children do not need to come into the foster care system in the very first instance and then eventually end up in congregate care, we should ensure that that is possible, and your discussion draft supports that by providing supports to family members before kids ever even come into foster care.

But if they do come into foster care, we believe very strongly that, before any child is placed in a congregate care setting, there needs to be a judicial review and that the child welfare agency needs to demonstrate that they have done an evaluation of the child and that there is a compelling reason to place that child in that facility, that the facility has the capacity to meet the indi-

vidual needs of that child, and that they have a plan to get them back into a family in a reasonable period of time.

So the first step is, you keep kids out of foster care if at all possible. Two, you should document that they need to be placed in congregate care. And three, you need to support all families, including relative caregivers, so that they have the capacity to meet the unique and sometimes complex needs of children who have experienced trauma and come into the foster care system.

We know we can do this. We just need to actually do something bold in legislation that tells States, this is what we expect of you, and we are going to give you resources to make it possible.

Senator WYDEN. Mr. Chairman, my time is up.

I would only say, Ms. Chang, that sounds very constructive. I would like you to start working with the bipartisan Finance Committee staff, Ms. Berntsen, who worked on the draft. And I would like to note that her folks are here. So we are very proud of the Pacific Northwest, the great work done by Ms. Berntsen, and we are happy to have the family here.

But this can be done in a bipartisan way, colleagues. This should not have happened to Ms. Gruber, and what we need, Ms. Chang, is for you to work with the bipartisan staff, and let's get this done.

Thank you, Mr. Chairman.

Senator GRASSLEY. Senator Stabenow, then Senator Casey, and then Senator Bennet.

Senator STABENOW. Well, thank you again, Senator Grassley, and to Senator Wyden, thanks. I share your passion and commitment on this.

This is a very important hearing, and we need to do much, much more to shine the light of day on what is happening.

Ms. Gruber, again, to echo what other colleagues have said, thank you for coming and sharing what has to be an incredibly difficult story to tell, but the good news is you persevered. And congratulations on your recent graduation, your new job, and your commitment to continue to tell the story, because what happened to you should not have happened, and you can help us make sure we stop it from happening to any more young people.

None of what has happened to you is your fault, and it is great to see that you are able to go on and understand that. I hope you do understand that and are able to go on and understand that you can really make a difference.

Mr. Reynell, thank you for sharing your story as a foster parent. James is lucky to have you, and I know you are lucky to have him, and so it is great.

First, let me say, before talking about a particular subject—and to follow up on Senator Wyden's proposal to increase funding for prevention and family services, which are so critical—Ms. Chang, when we talk about making these changes, do we have to wait for legislation?

What can you do in the Department through rules? How can we address this question? I have so many questions for you. Ms. Gruber's uncle, did he have appeals? I mean, what is the process here?

We are swallowing up children day after day in bureaucracy, and this has gone on for years and years and years—and we try to fix

it. I have been working on this for years and years, and, in Michigan, we have put in timetables to move children to adoption and do these other things, and then we still have situations happening.

So do we need to pass legislation and all that it takes to do that, or what can you guys just do to fix this internally?

Ms. CHANG. Senator Stabenow, thank you so much for the question. I share your frustration. If there was anything in my power that I could do to make a significant shift in the way children are placed in congregate care settings, I would absolutely do it.

That is one of the reasons why we spent so much time developing this data brief. We wanted to understand the issue and also see what we could do through administrative policy.

Unfortunately, I do believe that legislative change is necessary. The Congress has done so much over many years, with much of your leadership here, to change child welfare policy. You have made more clear through legislation that States do have the discretion to waive individual things like whether you are missing one extra bedroom in your house for relatives. And the reality is, that has not significantly changed action among States.

I think it is going to take something with a lot of vision and clarity from Congress to really change the way we do business and the way we approach families.

Senator STABENOW. So, in order for us to get common sense, that you do not have to have an extra bedroom, that rather than a young person being on the street, maybe you ought to bring in a portable bed that you can get from any store, a blow-up mattress—I have those in my house for guests—we have to actually pass a law to fix that?

I just have to say, we had better all see this as a wakeup call. For common-sense things like a loving uncle versus the street, it does not seem like a tough question to me. And so I want to work with you on this, but I would just say that I am not suggesting that somehow there is not all kinds of bureaucracy there, but this ought to be able to be fixed.

But let me ask, when we look at the use of congregate care—because I want to talk about something else as well—I am worried that we are going to be hard-pressed to reduce the use of congregate care without making key investments in a wide range of programs to support children and families.

I realize that we need to do that probably before they even interact with the foster care system. That is really what Senator Wyden was talking about as well, and I am appreciative of working with Senator Grassley on the caucus.

One of those areas is therapeutic foster care, and I wonder if you might speak about the clinical intervention for youth who have serious mental or emotional or behavioral needs, which, for a variety of reasons, is true for children being put in this situation, and that, if we are looking at therapeutic foster care, we are looking at children being placed with a highly trained foster parent and we see the intensive in-home services and hopefully the least restrictive outpatient placement.

As you know, there are approximately 40,000 children in all 50 States receiving services right now, but there is no Federal definition under Medicaid for this.

So we have had legislation. I have had it for a number of years. Senators Baldwin and Portman have introduced a bill that I am proud to be cosponsoring with Senator Casey and Senator Brown to define therapeutic foster care benefits to increase quality of care. It is low-cost.

I hope, Mr. Chairman, that our committee could pass that. It is a really important step that we could take.

Ms. Chang, I wonder if you might speak to that and the tools that you need to improve support services for children and ultimately keep them in loving homes and out of congregate care.

Ms. CHANG. Thank you. We absolutely believe that therapeutic foster care is a crucial component of reducing the reliance on congregate care. What we are saying is that children can get therapies and intervention in homes sometimes better than they can in institutional settings.

But in order for that to be realized, we need to provide, as you said, the supports necessary to make that possible. So we think that has at least two components. One is training case workers so that they can provide supports and identify what a family needs.

A child's need when it is that intensive is not going to be static. So from the first time the case worker sees the child, over time those needs may change. A case worker needs to have enough training to really understand the evolving needs of the child and the family.

So we would have enhanced rates of reimbursement for specialized training for case workers. We would also provide them with enhanced rates of reimbursement for providing that type of support to families, because we know if you have a caseload of children with specialized needs, you are not going to be able to see as many families because your workload is going to be higher. So we think that is a really important component: really supporting case workers.

On the other side, families need to be trained. The good news is that relative caregivers, Lexie's uncle, he could be trained to be a therapeutic foster parent. This is not limited to strangers or professionals.

If they get the proper training, they could take kids into their homes and provide that therapeutic environment themselves.

Senator STABENOW. Thank you.

Senator GRASSLEY. Senator Casey?

Senator CASEY. Thanks very much, Senator Grassley. I want to commend the words of Senator Wyden and his passion and his work on this for so many years.

I realize that most of what we have to do is by way of legislation. Sometimes there is no other way to correct a problem than to pass a statute or to revise what we have done in the past.

But I want to explore with the panel some ideas about doing things in the near term absent the passage of a bill, because you might have noticed that, around here, it does take a while to get a bill passed.

So I want to start with Ms. Gruber. I did not hear your testimony, but I read it. You have become so familiar now to people in the room. Is it okay if I call you Lexie? Everyone is calling you

Lexie. We do not usually do that. We usually have titles and all of that.

But I was struck by a couple of things you said in your written testimony that are so fundamental to how human beings interact and what we all need in our lives growing up. You said on the second page of your testimony, quote, "I desperately needed the love and support of a family." On page 3, you said, "I wanted to be able to make my own sandwich again," something that simple. When you are trying to make your way in the world, you want to be able to have some freedom to do something that fundamental and simple.

At the bottom of that page, you had a question: "Why was I being penalized for having been removed from an abusive home?" On the next page, you say, "I did not receive much emotional support or affection."

So I cite those all to indicate that what you were seeking was not some sophisticated policy or even a trained expert to help you through the difficulty you were facing. You just needed the basics that a family can provide or something comparable to that.

That is a very powerful statement, and sometimes here we have all kinds of theories or policy discussions, but once in a while, it is that simple and that profound at the same time.

Maybe I will start with you, but before I do that, I also want to say how much I was impressed by what you have overcome. Your story is kind of a triumph of the human spirit.

I noticed in your testimony you said you graduated from Quinnipiac University magna cum laude. I took 4 years of Latin. I know that means with high honors. So you should be very proud of that.

But what would you hope that we would do short of passing a bill like the one Senator Wyden is talking about, which we hope to do and should do? Between now and then, what would you hope we would do?

Ms. GRUBER. Thank you for your kind words and compliments. I think sometimes when we—I used to work in the House, and I think, when we are on Capitol Hill, we get all wrapped up in the Federal policy and kind of this utopia. We are having a very utopian conversation about how we have these really difficult needs and no place to put these kids.

In an ideal world, what could we do? When you are on the ground level and you are on the State and city level, you are really dealing with these immediate problems. You do not have the privileges and luxuries of being able to theorize the way that we have the privilege of doing here.

I think that we need to really empower the people who work in group homes. The staff at my group home, they tried so hard. They were paid barely over minimum wage, and they had to work three to four jobs, and I think that is a violation of ethical labor standards. And I think that we need to empower our employees who are taking care of these vulnerable children so that they can take care of themselves and their families and come to work ready to care and support us in the way that we need too.

Senator CASEY. Thank you. I have only less than a minute, but, Doctor, is there anything you could add to this in terms of kind of short-term things that we could do?

Dr. KOHOMBAN. Lexie is right. The front lines of our work are highly stressed, but I think organizations and leadership can provide some flexibility.

If Lexie had been at Children's Village—I wish she would have been—I would have hoped that she would have called me directly and said, "You are the president of Children's Village. Why is this happening to me?"

I think our organizations are often too hierarchical, and the people who can truly make the decisions are out of touch at times. Not that they do not care, they are just too busy. And if we could drive down a culture that says that the most important thing I do as the president of Children's Village is make time for someone like Lexie, there is nothing more important than that, that can make the difference between how she feels and her ability to persevere through the system.

So there are things we can do locally.

Senator CASEY. Commissioner, you answered a couple of questions. Maybe I will have you answer one in writing. We are over time.

But is there anything you want to say, Mr. Reynell?

Mr. REYNELL. Just that the love of a family, like Lexie was saying, is definitely that catapult that these children need who are in residential treatment.

My son James was not moving forward with his treatment while he was living there, and everybody was amazed when he was catapulted to reading and writing at grade level and being able to participate and be part of a family again. And they kind of said, "Why do you think this is; what did you do differently; what tutors did you use; what therapist did you use?" And I said, "Really I think it was all about the love of a family."

So I think, really, finding these children what their forever family is going to be, whether it is kinship care or through adoption, is definitely the way to go.

Senator CASEY. Thanks very much.

Senator GRASSLEY. Senator Bennet, I hope that you might be the last one and then would close us down. I have an 11:15 appointment. Would you do that?

Senator BENNET. I would be happy to do it, Senator Grassley.

Senator GRASSLEY. And I want to thank all of you, not only for this Senator, but Senator Hatch, who could not be here, and Senator Wyden. They both have important pieces of legislation on the floor. They are not ignoring you. This is a very important issue. It involves things that some of us, like Senator Wyden had said, have been working on since the 1990s.

Thank you very much.

Senator Bennet, go ahead.

Senator Bennet [presiding]. Thank you, Senator Grassley.

I would like to thank the panel. I missed your testimony, but I read your testimony and it was excellent, and I appreciate it.

Day after day, I am amazed in this place how many unintended consequences there are that flow from the legislation that we write, and I do not think that is particularly excusable, but when it comes to our kids, it is even more inexcusable than anything else we do.

I actually wish the entire committee had been here to hear this discussion. And I know with Senator Casey and others, we will work very hard to make sure that this testimony actually does result in legislation.

I wonder, Ms. Gruber—your testimony was so compelling, the life you have lived is so compelling—if you had to boil it down to one or two things, as we close this hearing, that this committee ought to pay attention to as we move forward, and I know you have said versions of it before, but just to simplify it and to have it on the record, what are those one or two things?

Ms. GRUBER. Well, I think probably the most important thing is that we have to believe in and empower our most vulnerable children.

I think one of the reasons why I ended up in a group home was because they thought I was a lost cause, that I was not going to go anywhere in life.

I am going to have an incredible life. I am going to do incredible things, and I know every child in foster care can too if they have someone who believes in them. So we have to change the way that we feel about and value vulnerable and sometimes broken children.

I think, second, it is so important for us to remember that the sex trafficking that occurs in group homes needs to be discussed, and it needs to have ended yesterday. Unfortunately, people think that sex trafficking happens in foreign countries, but it happened at the home that I lived in. And unfortunately, some of my foster sisters who—I actually called them to get some feedback on my testimony. Some of my foster sisters who were trafficked are still in prostitution. They are still addicted to drugs. Some of my foster siblings are dead, and I want us to remember the power of that, because, if that is one thing that we can discuss today and that we can change today, we need to end the sex trafficking of these girls.

Senator BENNET. Well, they are fortunate to have you as an advocate, and we will get after it here. I want to assure you of that.

Ms. GRUBER. Thank you.

Senator BENNET. Ms. Chang, in Colorado, our waiver has allowed a large degree of flexibility to reduce dependence on group homes and congregate care. We have been able to not just target children who need the most immediate help, but children who could be at risk of entering foster care as well, and this is an area that our office is interested in working on with Chairman Hatch and Ranking Member Wyden.

How is HHS, through its waivers, helping States reduce their dependence on congregate care, and what will happen in 2019 when these waivers expire?

Ms. CHANG. Thank you for that question. I do think the waivers provide a really interesting glimpse into the struggles and the heart of many State child welfare agencies. When we looked at the over 27 States and tribes that have a waiver, what we found was that most of them have decided to use the dollars that they have flexibility to use to invest in prevention.

What they really are saying is that, one, kids who do not need to be coming into foster care are unnecessarily coming in, and they are coming in because we do not have access right now to a guaranteed source of Federal funding for prevention services.

The second is that they are investing in interventions to keep kids out of congregate care settings or to get them out of congregate care settings. This is a really complex issue. There are issues around the needs of children, but this is also, at the heart of it, a business issue.

So one of the things that Colorado is struggling with is that the congregate care providers are a very strong business entity that fights to stay in business, and one of the things that we found among States that have successfully reduced the use of congregate care is that States have been able to negotiate with those businesses to have a different business model.

What they said is, we will pay you to care for kids in their homes instead of caring for them in institutions. Now, that has worked in States that have had the money and the flexibility to make those decisions. We want to see a shift in Federal policy so that you are not subject to kind of the whims of geography and whether your State legislature has decided to use its money that way.

Senator BENNET. Doctor, do you want to get in on this conversation?

Dr. KOHOMBAN. Private providers need to find ways to change and transform, or I think we should go out of business, because we should not let our business interests get ahead of what is good for kids. And I think Lexie's example is an unusual one. Most of our children do not reach the heights that Lexie has reached. So please remember that Lexie is an anomaly and we love her for that, but we need to have 10,000–50,000 Lexies every day.

Senator BENNET. She is the patron saint of lost causes, I would say.

I think that is a very fine way to end this hearing. I want to thank all of you on behalf of the committee for appearing here today.

I want to thank all the Senators who participated. This, as I said, has been a very compelling discussion, an unusually compelling discussion for this place, and I appreciate everybody's participation.

Any questions for the record should be submitted by no later than Tuesday, May 26th.

This hearing is now adjourned. Thank you for being here.

[Whereupon, at 11:53 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MARIA CANTWELL,
A U.S. SENATOR FROM WASHINGTON

I applaud the Chairman and Ranking Member for holding today's important hearing on the use of group homes in states' child welfare systems. While group homes may serve a purpose for some children in specific circumstances, we should be exploring ways to responsibly limit the use of congregate care so that it supplements, rather than supplants, family-based care. I look forward to working with the Committee to improve federal incentives under the title IV-E program, so that, among other aims, we can cut down on the use of group homes and congregate care when better options exist for foster youth.

PREPARED STATEMENT OF JOO YEUN CHANG, ASSOCIATE COMMISSIONER, CHILDREN'S BUREAU, ADMINISTRATION ON CHILDREN, YOUTH, AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, and Members of the Committee, it is my honor to appear before this Committee on behalf of the Department of Health and Human Services (HHS). The Administration believes that children are best served when raised in safe, loving families, and congregate care use should be limited to children who need intensive residential care due to medical issues, and only for as long as those interventions are needed. That is why the President's Fiscal Year (FY) 2016 Budget includes a proposal to limit the use of congregate care, to increase monitoring of congregate care use, and to support family-based care as an alternative to congregate care. We are grateful to you for having this hearing and bringing more attention to the issue.

My name is Joo Yeun Chang, Associate Commissioner of the Children's Bureau. I have worked as a national advocate on child welfare policies as a senior staff attorney at the Children's Defense Fund, and immediately prior to my appointment to the Bureau, I worked at Casey Family Programs Foundation where I worked closely with state and local child welfare agencies. In my current role, I oversee the Federal foster care and adoption assistance programs as well as a range of prevention and post-permanency initiatives.

At HHS, we work with the state and tribal agencies that run child welfare systems to ensure that vulnerable children in foster care are placed safely in the least restrictive, most family-like settings available and that are in the best interests of each child. Federal law gives states flexibility and discretion to make decisions for a child on a case-by-case basis to ensure that the best placement is made and the individual safety, permanency, and well-being needs of the child are met.

According to the most recent data we have available, in FY 2013, there were 402,378 children in foster care, including both IV-E and state-funded foster care. Over the past 15 years, we have seen a dramatic decline in the total number of children in care, from a high of 567,000 in FY 1999 to a low of 402,378 in FY 2013. In FY 2013, the average age of a child in foster care was nine, but very young children and teens represented the highest subgroups of children in care. Seventy-five percent of children in foster care lived in a foster family home, 14 percent lived in congregate care settings, and 5 percent have returned home on a trial basis. Most children and youth in foster care are there for less than 2 years; 20 percent are in

care for 2 to 4 years; and 8 percent are in care for 5 years or longer. Of all exits from care during the year, the majority (87 percent) exited to a permanent home. However, far too many children spend too much of their childhood in care without the benefit of a safe, permanent family. For children entering care during the year, less than half reached permanency within 12 months, and approximately 8 percent of those children later re-entered care within 12 months.

Congregate care includes care in a group home or institution such as a child care institution, residential treatment facility, or maternity home. There is consensus across multiple stakeholders that most children and youth, especially young children, are best served in a family setting rather than in group or institutional care. Congregate care should be used not as a default placement setting due to a lack of appropriate family based care, but as part of a continuum of interventions; the question is not if congregate should ever be used, but when, for whom, and for how long. The Administration believes that stays in congregate care should be based on the specialized behavioral and mental health needs or clinical disabilities of children. It should be used only for as long as is needed to stabilize the child or youth so they can return to a family-like setting.

In March 2015, the Administration for Children and Families (ACF) issued a data brief providing a national look at the use of congregate care in child welfare. The brief was developed to provide a basic understanding of the use of congregate care, and answer the following questions about congregate care utilization:

- (1) Who is placed in congregate care?
- (2) How long do children stay in congregate care?
- (3) Are there any predictive factors?
- (4) What are jurisdictional differences in the use of congregate care?

To answer these questions, the Children's Bureau, within ACF, conducted an analysis of state-reported data through the Adoption and Foster Care Analysis and Reporting System (AFCARS). A point-in-time analysis of AFCARS found that as of September 30, 2013, (the most recent data available), an estimated 14 percent of all children in foster care were in congregate care.

In addition to point-in-time data, we created longitudinal cohorts of children who experience congregate care. We followed children who entered care in 2006, 2007, and 2008 over 5 years. Older youth consistently represented a majority of those who experienced congregate care; they made up 69 percent of children and youth who experienced congregate care in the 2008 cohort. In our analyses, we found that we could effectively group these older children on the basis of diagnosed clinical disabilities and/or removal and placement into foster care due to a "child behavior problem" (CBP). The aforementioned grouping resulted in four subgroups:

- (1) children *without a clinical diagnosis* or CBP but had very likely experienced some type of maltreatment, (2) children with at least a mental health diagnosis according to the statistical manual of mental disorders (*DSM*), (3) children with a CBP excluding all disabilities, but who may have experienced some maltreatment and finally, (4) children with any clinical disabilities excluding a *DSM* diagnosis.

For the older youth population in congregate care, children whose reasons for removal from their home include having been identified as having a CBP but who do not have a reported *DSM* diagnosis, nor any other disability represented 44 percent of the children in the cohort who experienced congregate care. Children with a *DSM* diagnosis represented 21 percent, children with a clinical disability other than a *DSM* diagnosis represented 6 percent, and children with no clinical indicators, nor a CBP comprised nearly 29 percent of the children in the cohort who experienced congregate care. Among youth with a social/emotional issue, those with a CBP were more likely to initially be placed into congregate care for treatment; youth with a *DSM* diagnosis were more likely to be subsequently placed in congregate care because they were not able to safely remain in traditional foster family care. Overall, results indicate that youth with a *DSM* indicator and CBP indicator may experience a need for higher levels of care. Children with a *DSM* diagnosis were more likely to have congregate care as a subsequent placement, be previously adopted, and have three or more placement moves compared to the other subgroups. Children with a CBP indicator were more likely to enter congregate care as their first placement, have only one or two placement moves, and exit to permanency. These children also were more likely to reenter care and be transferred to another agency, which may indicate a need for longer term stabilization in an alternate setting.

Further analysis of those children in care as of September 30th, 2013 (point-in-time data), demonstrated that children currently in congregate care are almost six times more likely to have a “child behavior problem” designation and three times more likely to have a DSM diagnosis compared to children in other foster care settings. Also, on average, these children had spent 8 months in their current congregate care setting compared to 11 months for children in non-congregate care settings. However, the overall time in foster care was longer for the children in a congregate care setting compared to those were in settings other than congregate care, with an average of 27 months compared to 21 months respectively.

There has been a significant decrease in the percentage of children placed in congregate care settings in the past decade, and this reduction is at a greater rate than the overall foster care population. Proportionately, children in congregate care comprised 18 percent of the foster care population in 2004 and 14 percent in 2013. While these trends suggest that child welfare practice is moving toward more limited use of congregate care, the depth of improvement is not consistent across states, and in some states the use of congregate care has increased.

In order to understand how states have reduced the use of congregate care at the state and local level, HHS interviewed a number of state and local officials. The data brief highlights practices that states and local jurisdictions have used to shorten lengths of stay in congregate care, develop alternative interventions for children and youth with complex social/emotional needs, and increase the effectiveness of congregate care as an intervention for those who need it for limited periods of time. A number of states shared that increasing placement with relatives has helped reduce the need for congregate care. For example, Texas has placed an emphasis on family finding and kinship placements in response to the passage of the Fostering Connections to Success and Increasing Adoptions Act of 2008. An indirect result of increased placements with kinship families has been a reduction in the numbers of children placed in congregate care. Utah has developed a method of evaluating its congregate care programs (e.g., outcome measures, qualitative interviews with youth) to ensure that children who need residential services are placed with providers who have demonstrated an ability to meet those particular needs.

Based on the findings from the data brief and the insights we gained from states that have significantly decreased their use of congregate care, the Administration developed a proposal in the FY 2016 President’s Budget to reduce the use of congregate care by increasing monitoring of congregate care use and supporting family-based care as an alternative to congregate care. The Administration’s proposal for family-based care impacts any child who is in, or at-risk of being placed in, a congregate care setting. The proposal would amend title IV–E of the Social Security Act to provide additional support and funding to promote specialized family-based care as an alternative to congregate care for children with behavioral and mental health needs, and provide oversight when congregate care placements are used. The proposal addresses four specific areas:

- It requires an initial justification of appropriateness:
 - If a child must be placed in a congregate care facility, title IV–E agencies would be required, as a condition of a child’s title IV–E eligibility which provides Federal assistance with the cost of caring for a foster child, to justify congregate care as the least restrictive foster care placement setting appropriate to meet the child’s needs. Title IV–E agencies would be required to document their assessment of the child’s medical and behavioral health needs that indicate a congregate care setting is necessary. This assessment also would identify the specific goals the child must achieve for discharge to a lower level of care and a more family-like setting, and the time frame in which this transition will occur.
- It would require the continued justification of the appropriateness of the congregate care placement:
 - States would be required to request a judicial determination at 6 months and every 6 months thereafter that the placement in the congregate facility is the best option for meeting the child’s needs and that the child is progressing towards readiness for a more family-like setting.
- It provides for smaller caseloads and specialized case management:
 - Title IV–E agencies would be reimbursed with 60 percent Federal financial participation (FFP) for specialized casework, and 80 percent FFP for specialized caseworker training. This would provide support for specialized case

management where caseworkers would have smaller caseloads and receive specialized training so that the caseworkers can focus on family-based care. Specialized case management will vary at state discretion, but overall worker caseloads would be sufficiently low (approximately 1:10) to allow for workers to provide intensive work with the foster family, child, and the child's family. This would include developing, implementing, and monitoring the child's treatment plan, frequent in-person contact and consultation with the foster family, and permanency planning with the child's family. Workers would receive specialized training in such things as behavioral management techniques, and treatment for emotional disturbances.

- It provides specific/targeted foster parent training and support:
 - The proposal would provide specialized training and compensation for foster parents who provide a therapeutic environment for a child. A therapeutic foster home is one with specially trained foster families who can provide support and treatment to a child with behavioral and/or mental health challenges.
 - It would provide title IV-E reimbursement for the supervision costs for children who may need specialized services during the day.

This proposal presents a concerted effort to limit the use of congregate care facilities for children in foster care by increasing investments in family-based care for children who have mental, social, or behavioral health needs and monitoring the use of congregate care. The Administration estimates this proposal to cost \$78 million in FY 2016 and reduce costs of title IV-E Foster Care by –\$69 million over 10 years. As placements in a congregate care facility are significantly more expensive than placements in a foster family home, the main source of savings in the proposal is from the reduced use of congregate care facilities for foster care placements. This proposal also includes supports for foster families and caseworkers; these investments will somewhat increase expenditures on other proposed and existing title IV-E activities especially in the first few years of the proposal. Overall, this proposal will result in a reduction in expenditures on maintenance payments as children are placed in less restrictive settings that best meet their needs.

I very much appreciate the Committee's interest in the issues raised today and the opportunity to speak with you. We look forward to working with you to address this crucial issue and improve services to some of our most vulnerable young people. I would be happy to answer any questions.¹

PREPARED STATEMENT OF ALEXANDRA "LEXIE" MORGAN GRUBER,
FORMER FOSTER YOUTH

Thank you Chairman Hatch, Ranking Member Wyden, and Members of the Committee for the invitation to be here today. My name is Alexandra Morgan Gruber, but I prefer to be called Lexie. I am a graduate of Quinnipiac University and, most importantly, I am a foster youth. I am humbled and thankful for the opportunity to share with you my experiences living in foster care and group homes.

My story begins at the age of 15 when the Connecticut Department of Children and Families removed me from my biological family. Although I am not comfortable sharing the events that necessitated my removal, I will say that my childhood was often distressing and chaotic. As a result, I suffered from severe anxiety and depression. When I entered foster care, I was traumatized from losing the only family and home I had ever known. I was also incredibly confused about the situation. My social worker and lawyer never explained to me why I was removed from my family. I felt like it was my fault. Overall, my entry into foster care served to exacerbate the symptoms of my post-traumatic stress disorder.

I believed that DCF was going to find me a loving family. At first, I was placed with my uncle. Being in a familiar and loving environment helped me begin to heal from both my stressful childhood and entry into foster care. Two months later, my social worker informed me that my relative's home did not have enough bedrooms to meet agency regulations and I would have to be removed from his home. A waiver could have been filed so I could remain in my uncle's home, but department policy

¹All data cited in this testimony is from the: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau, Adoption and Foster Care Analysis and Reporting System (AFCARS); data as of July 2014.

carried more weight than permanency. My uncommitted social worker did not listen to my pleas to stay with my relative. Instead, she picked me up from his home and dropped me off at an emergency youth shelter. When I moved in, the staff watched as I struggled to carry trash bags filled with the few belongings I had left. I collapsed onto my new bed—a graffiti covered bed frame in a filthy room. I had lost everything, and now I was *homeless*.

The next 2 years were spent in a dizzying array of shelters and temporary foster care placements. Sometimes I would stay in a placement for months, and others I would stay for a single day. The instability in my life exacerbated the symptoms of my PTSD. My well-being deteriorated as a result of the often harmful, neglectful environments I lived in. After nearly 2 years of being bounced between placements, DCF attempted to reunify me with my biological family. I wanted to be with my family again, but the situation turned sour and I was quickly taken back into foster care. The failed reunification with my family left me feeling emotionally wounded, abandoned, and hopeless.

At this point, DCF decided to find a group home placement for me due to a lack of foster care placements and my depression. I was crushed to learn that there weren't any homes for me, as I desperately needed the love and support of a family as I came of age. I was even more hurt that I was being denied a family because of my PTSD. In many ways, the group home was made to feel like a punishment for my inability to control my unusually depressed behavior.

They placed me at Allison Gill Lodge, a therapeutic group home located in Manchester, Connecticut. When I walked through those doors on the first day, I felt like a wrongly accused prisoner walking into a jail to serve time for a crime they did not commit. My parents did not face any consequences for their actions and were still able to enjoy the familiar comforts of home. I was the only individual whose life was drastically altered as a result of my entry into foster care. The injustice of the situation was viscerally unsettling, and led to me experience deep anguish as I tried to comprehend why I was being punished for things outside of my control.

The group home looked more like a business than a home. The walls were adorned with informational posters like those in doctors' offices, rather than the familial photos and memorabilia that decorated my friends' houses. Outside the staff office on the second floor hung a whiteboard where the staff wrote down information, such as the weather and what was for dinner, instead of informing us of these things in person. Above an industrial hand-washing sink in the kitchen hung a licensing certificate from the municipal health department, making our kitchen look like a fast food restaurant. Health regulations prevented residents from preparing their own food or entering the fridge without gloves, and the cabinets were locked to prevent us from stealing snacks when the budget limited the availability of food. One of the reasons why I wanted to be granted home visits with my biological family was because I wanted to be able to make my own sandwich again.

The disciplinary system, known as a "level system," was also more militant than familial. It was a punitive system that granted us age-inappropriate privileges as long as we maintained absolutely perfect behavior. There were three levels. When you first entered the group home, you were on "individual phase." You only got about 30 minutes on the computer, one phone call to someone outside of your family, and couldn't be alone in a room without staff. Eventually, you could work your way up to the third phase, known as "community phase," if you maintained absolutely perfect behavior for an extensive period of time (if I remember correctly, it took me 1 year to attain this phase). On community phase, you could go for an hour walk by yourself. One of my fondest memories at the group home was being able to go for a walk to the cornerstone by myself and buy my favorite bag of chips with the meager allowance I earned. Those few sweet moments of silence allowed me to leave the drama of the group home and enjoy the peace of the outdoors. These privileges could be taken away in a single second. Any "bad behavior" such as swearing or talking back meant that you had every privilege taken away—no computer, no phone, and none of those precious few minutes outside by yourself. There was no consideration for normal teenage behavior, and we were punished for things that normal ten-year-olds would get away with in a family. These "privileges" were the only thing that kept me sane and I felt constantly on edge, afraid that my lifeline would be taken away at any moment. I could not understand why I had to act perfectly just to have the basic social privileges of a child. Why was I being penalized for having been removed from an abusive home?

In addition to these abnormal aspects of group-home life, my social life lacked any hint of normalcy. My high school years did not include the quintessential milestones

that so many of my peers got to experience. Extracurricular allowed me to spend more time outside of the group homes, but finding a ride was difficult as the Department of Children and Families needed a criminal background check on anyone who transported me. If I wanted to go to a friend's house, each member of my friend's family would have to undergo a criminal background check. It was hard enough to deal with the stigma of being a foster kid in suburban Connecticut, and I feared that my friends and their parents would think I was a delinquent if I told them they needed a background check so I could come for dinner. Making friends was pointless without being able to sustain the bond outside of the classroom, so I quit trying to make friends and built emotional walls.

Often, the group home residents were treated like second-class human beings. We were allotted two phone calls a day to friends on a pre-approved contact list and all phone numbers written down, presumably to be used to help them find a girl if she ran away. Social media was completely off limits. Every television show I watched and website I used was monitored by the staff, and they did not allow me to view anything age-appropriate.

Inside the home, I did not receive much emotional support or affection from the staff that served as my primary caregivers. The group home was staffed in rotating shifts of staff. Although the schedule was often solid, I never managed to remember who was coming in at what time or day. In hindsight, I realize that this was because it is abnormal for a young person to be cared for in this way and my brain simply could not process that information. The staff were often tired and on edge due to being overworked and underpaid. They tried their best, but they weren't supported in their roles and this was reflected in their interactions with residents. They would often remind us that they only put up with us for the paycheck and normalized the idea of being cared for in exchange for profit, which led some residents to engage in sex trafficking. Additionally, the staff were not allowed to show us physical affection. Hugs were absolutely off-limits and they would be fired if they said they cared about us in a non-professional way. During my entire 2 years in the group home, I was only told "I love you" one time. The staff pulled me aside and told me, and I burst out crying because I needed to hear that so badly. The lack of physical and verbal emotional support led all the residents, including myself, to seek out attention in the community in unhealthy ways. I didn't understand why I was taken from people who didn't love me only to be given to adults who could not care less about me.

The group home staffs were also ill equipped to diagnose and handle the symptoms of my post-traumatic stress disorder. From the very first day, they saw my unusual, depressed and erratic behavior as an internal, biological defect rather than a series of perfectly normal coping mechanisms for my experiences. During my intake evaluation, the group home therapist told me that I could possibly go to a foster home if I "improved my behavior." They saw my erratic, depressed behavior as "acting out" when in reality I was a traumatized child trying to make sense of an irrational situation. The daily staff also failed to appropriately handle my outbursts. When I acted out, I was forced to sit alone on the stairs. The staff did not try to speak calmly to me to understand why I was acting out, and resorted to easy tactics like time-outs to correct my actions.

I was also forced to take a myriad of medication. Every week, residents of the group home had to attend a mandatory meeting with a psychiatrist. If we skipped this meeting, we would be put on "individual phase" and therefore I attended out of fear of losing my beloved, meager privileges. The doctor prescribed me a pill for every emotion I was experiencing. If I was moody during our visit, he'd give me a new prescription and claim that my behavior was due to mental illness rather than seeing moodiness as a normal teenage response to being forced to see a doctor. He also over-diagnosed me. If I did so much as swear during the meeting, he'd give me a label of Oppositional Defiance Disorder and give me a medicine to counteract the illness. At some points during my stay at the group home, I was so overmedicated that developed a tic in my face. Although I did not like the side effects of the medication, I had no choice but to take them. The staff administered the medicine and inspected under our tongues to make sure we swallowed. If we refused our medication, we would be put back on individual phase. The group home staff did not pay attention to my reactions to the medicine. In fact, the only person who kept an eye out was my biological mother. When she saw me repeatedly involuntarily scrunch my face during a home visit, she called the doctor and expressed concerns that I was overmedicated. Due to her watchful eye over the doctor, I was soon taken off that medicine and the doctor was more careful in the future. I still have a tic in my face as a result of that medication. If my mother did not speak up, I likely would

have experienced more dangerous side effects of medication. When I left the group home, the long list of diagnoses given to me by the group-home doctor were dismissed and my depressive behavior was deemed a result of significant, complex childhood trauma.

Overall, I was at the group home for about 1½ years. During this time there was little to no effort to find me a permanent family. During my intake evaluation, the group home therapist told me that they would try to find me a family if I “improved my behavior,” as if this my stay at the group home was a trial for me to prove I was worthy of being loved. When they said “behavior” they were referring to my seemingly random fits of anger and sadness. These emotions were rooted in my belief that I was unlovable and were a result of the instability in my life. The staff and my social worker saw these behaviors as proof that I was unlovable and unworthy of a family.

I eventually left the group home in August 2011 to attend college. My transition from the group home to the dorm room was incredibly difficult. The staffs at the group home were the only adults I knew, but policy prohibited them from contacting me when I moved out. I was left with no dedicated adults to support me as I struggled to acclimate to a college campus. I spent my first semester in an incredibly dark depression, crying myself to sleep and struggling to focus in class. When the dorms closed, I had no home to return to. As a result of these challenges, I contemplated dropping out of college.

Today, I am a 22 year old woman living a healthy, happy life. I graduated from Quinnipiac University with honors this month, and am moving to DC soon for a job at First Focus as Director of Policy and Research. My post-traumatic stress disorder has been treated and I am now able to fully enjoy the sweetness of every single moment. It is very difficult for me to talk about my experience in-group homes. To be truthful, I’d rather put it behind me and just enjoy the fact that my life is better now. But I cannot do that because I need to ensure that no other innocent child endures what I experienced.

I now know that I am loveable, valuable, and deserve a healthy family. It took 4 years of intensive therapy to allow me to reach this conclusion. However, my experiences in-group homes left me with emotional and physical scars that may never heal. I often have nightmares of being back in a group home, unable to leave and confused about why I am there. I wake up in cold sweats, scared that I will lose all the blessings in my life and have my autonomy taken away again. Relationships are still difficult for me, and I struggle to connect with others. Many people say I am successful and perhaps this is true if we are discussing my career. But I want to emphasize that as a result of living in this group home, I struggle to live a life of healthy connections and balance.

If someone were to ask me what group homes are like, I would tell him or her that group homes are modern-day orphanages. These institutions cannot provide the moral, ethical, or social learning that is essential to healthy childhood development. Every child deserves a family. When we remove children from unhealthy families, we make a promise to provide them with a healthier family that can nurture and support them. This is a promise that we must uphold. There is a series of data that shows that young people are being placed in these settings without good reason and are left for far too long. Additionally, a wide body of national literature demonstrates that youth in-group homes face poor outcomes once they age out of foster care.

The economic and social implications for these emerging adult’s well-being are significant and affect the entire nation. The moral implications also force us to ask whether our country should allow vulnerable young people to live in placements that are detrimental to their own well-being and that of the surrounding community. If the answer to that question is “no” then we must work quickly to ensure that government policies, such as those that govern group homes, align with our nations values.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today issued the following statement during a committee hearing examining how Congress can best address the challenges facing foster children in group homes:

As my colleagues know, last year, Congress passed and the President signed important legislation that improved the adoption incentives program, updated child support enforcement, and made a number of significant reforms to our nation's child welfare system.

A number of these reforms addressed issues associated with the sexual trafficking of children and youth out of foster care. These provisions were first introduced in legislation that I drafted, the Improving Outcomes for Youth at Risk for Sex Trafficking, which I referred to as I.O. Youth.

I am very pleased that key provisions in my bill are now the law of the land.

But our work to improve outcomes for youth at risk of being trafficked for sex remains incomplete.

Groups home, sometimes referred to as "congregate care," are literally breeding grounds for the sexual exploitation of children and youth. As the committee heard during a hearing on domestic sex trafficking of children and youth in foster care, traffickers know where these group homes are and target the children placed in them for exploitation.

While the provisions included in my bill will help improve outcomes for children and youth in foster care, a key feature of that bill—which was not enacted—would refocus federal priorities on connecting vulnerable youth with caring, permanent families. This would be accomplished by eliminating the federal match to group homes for very young children and, after a defined period of time, for older youth.

I know that some might have concerns about limiting federal funds for any type of placement. Here's how I look at it: No one would support allowing states to use federal taxpayer dollars to buy cigarettes for foster youth. In my view, continuing to use these scarce tax payer dollars to fund long terms placements in groups homes is ultimately just as destructive.

As Chairman, I will be working with Ranking Member Wyden and other members of this committee to come to a consensus on reducing the reliance on group homes. I hope we can put together draft legislation within the next few months.

I realize that in crafting the committee bill, members will bring their own priorities to the table. I want to encourage all Senators on the committee to do so.

The Ranking Member has recently introduced legislating that would promote the practice of intervening to keep children and youth safely at home before a difficult situation escalates and the child needs to be removed. I hope to work with the Ranking Member on his proposal as part of this exercise.

Additionally, we will attempt to address policies and practices that, as detailed in a BuzzFeed Media series, led to a number of horrific cases of severe abuse, neglect, and the tragic death of a little three year girl.

In order to inform the committee's work on how to address the policies and practices that contributed these horrific outcomes, Ranking Member Wyden and I wrote a letter to all 50 Governors requesting responses to a series of questions related to the oversight of private child welfare service providers.

I look forward to receiving answers to our inquiry and moving forward on this matter.

This hearing is an important first step in making progress on a number of key policy initiatives.

PREPARED STATEMENT OF JEREMY KOHOMBAN, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE CHILDREN'S VILLAGE, AND PRESIDENT, HARLEM DOWLING WESTSIDE CENTER

My name is Jeremy Kohomban, and I am President and CEO of The Children's Village and our affiliates, Harlem Dowling and Inwood House. We are members of the Child Welfare League of America, Crittenton Foundation and the Alliance for Strong Families and Communities. The Children's Village is also a founding member of the Annie E. Casey Foundation's Provider Exchange, which offers private providers peer consultants to help shift their business models toward home- and community-based services.

Founded in 1851 to serve New York City's children, The Children's Village has been home to some of the earliest examples of residential programs in the nation.

By the 1950s, facilities like ours had developed into what are now known as residential treatment centers. Today, our organizations provide a broad continuum of both residential and community-based services to more than 17,000 children and families each year.

I am here to tell you why, in the last decade, The Children's Village has been on a journey to undo our recent history. And why we are certain that, by doing so, we are doing a better job of keeping children safe and families together. I will tell you why we have moved with urgency to shift the mix of services we offer to children and their families. In 1998, nearly all our children were in residential settings. Today, 60 percent of our efforts are in the community and with families, and residential is used sparingly, like an emergency room.

The reason for this shift at The Children's Village is simple. We now know that residential care is not an effective long-term solution for children and families. In fact, it is often exactly the wrong intervention for most children, including teens, as two new reports underscore. One is the HHS report, *A National Look at the Use of Congregate Care in Child Welfare*. The other is the new policy report, released today, by the Casey Foundation, called *Every Kid Needs a Family: Giving Children in the Child Welfare System the Best Chance at Success*.

Today, I will share four crucial lessons The Children's Village has learned that align with findings from these recent reports. Those lessons are that:

1. Children belong in families, not in residential care.
2. States can and should invest in broad, community-based service arrays that provide brief, effective help for children and families facing crisis.
3. Providers can and should change their business models for helping children and families by moving away from residential care and investing in models that wrap our services around children and families in the community. And, crucially,
4. The federal government can serve an important role by acting as a catalyst for change. It can provide incentives and real supports for strong systems of community-based care.

CHILDREN BELONG IN FAMILIES

The Children's Village has its roots in the reform school movement of the 1800s. From 1851, when we first opened our doors, until a decade ago, our primary prescription was to remove and treat children away from families and neighborhoods that were considered "bad," often severely weakening or permanently severing family ties. We followed the best practices at the time. We had the very best of intentions.

But when we looked at our results, we found something profoundly unsettling. While we sought to help, often we did not. Despite our best intentions and desire to help, often we failed.

Our practices, like the practices of child welfare nationwide, managed to do the opposite of what was intended. Instead of helping children, often we unwittingly fed an intergenerational cycle of hopelessness and disconnection that fueled very poor outcomes. One result is children and parents who are despondent and struggling to gain the critical skills they need to support themselves, including the internal skills of resilience and hope. Children and families became system dependent; they never learned how to belong to each other and to act in a family, with the necessary give and take and tolerance for one another's successes and shortcomings.

Beginning in the early 1970s, our good intentions went even further astray as we became a primary pipeline for the dramatic and increasing overrepresentation of African American and children of color in long-term government-supported systems.

As the HHS report notes, today we know better. As it describes, there is now "a consensus across multiple stakeholders that most children and youth . . . are best served in a family setting."¹ Among the evidence for this: *Data indicate that, in*

¹D'Andrade, A.C. (2005). Placement stability in foster care. In G. Mallon and P. McCartt Hess (Eds.), *Child welfare for the twenty-first century*, New York: Columbia University Press.

Gleeson, J.P. (2012). What works in kinship care? In P.A. Curtis and G. Alexander (Eds.), *What works in child welfare* (Rev. Ed.) (pp. 193–216). Washington, DC: CWLA Press.

many communities, there is a poor fit between children's needs and available child welfare placements and services.

Today, not enough kids in the child welfare system live in families. One in every seven kids in state custody—nearly 57,000 children nationwide—are languishing in group placements when many of them could be and should be living in families.² Data indicate that African American and Hispanic children are more likely to spend the most time in group placements. Adolescents in residential care are more likely to be older, male and children of color; they are likely to have higher rates of socioeconomic, behavioral and juvenile delinquency challenges.³

Residential care cannot continue to be a default intervention. We have to stop thinking about the majority of children in foster care as children with chronic and persistent mental illness who need to be separated from society. Forty percent of children in residential placements have no clinical reason for being there. Forty percent! As one researcher noted, it is time for systems to become more rational, driven more by the needs of the child and family than the needs of programs and systems.⁴

My experience tells me there are better ways to help these children, whether they have a diagnosis or not. Children in child welfare systems may be traumatized. They may have really tough challenges that require skilled attention. But, as the Children's Bureau has said, children with behavioral concerns, trauma symptoms and mental health disorders can heal, recover and become happy, successful adults.⁵ Children heal and develop better in the context of belonging and family. Children need a different mix of placements and services than what we are now offering, in-

O'Brien, V. (2012). The benefits and challenges of kinship care. *Child Care in Practice*, 18(2), 127–146.

Walsh, W.A. (2013, winter). *Informal kinship care most common out-of-home placement after investigation of child maltreatment* (Fact Sheet No. 24). Durham, NH: Carsey Institute.

²A sample of research on the developmental importance of family: Barth, R.P., Greeson, J.K.P., Guo, S., Green, R.L., Hurley, S.H., and Sisson, J. (2007). Outcomes for youth receiving intensive in-home therapy or residential care: A comparison using propensity scores. *American Journal of Orthopsychiatry*, 7(4), 497–505, doi: 10.1037/0002-9432.77.4.497.

Dozier, M., Zeanah, C.H., Wallin, A.R., and Shaffer, C. (2012). Institutional care for young children: Review of literature and policy implications. *Social Issues and Policy Review*, 6(1), 1–25. doi: 10.1111/j.1751-2409.2011.01033.x.

James, J.S., Zhang, J.J., and Landsverk, J. (2012). Residential care for youth in the child welfare system: Stop-gap option or not? *Residential Treatment for Children and Youth*, 29(3), 48–65. doi: 10.1080/0886571X.2012.643678.

Lee, B.R., Bright, C., Svoboda, D., Fakunmoju, S., and Barth, R. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice*, 21(2), 177–189. doi: 10.1177/1049731510386243.

Wulczyn, F., Chen, L., and Hislop, K.B. (2007). *Foster care dynamics 2000–2005: A report from the multistate foster care data archive*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago. Retrieved from www.chapinhall.org/sites/default/files/old_reports/406.pdf.

³Berrick, J.D., Courtney, M., and Barth, R.P. (1993). Specialized foster care and group home care: Similarities and differences in the characteristics of children in care. *Children and Youth Services Review*, 15, 453–473.

Curtis, P.A., Alexander, G., and Lunghofer, L.A. (2001). A literature review comparing the outcomes of residential group care and therapeutic foster care. *Child and Adolescent Social Work Journal*, 18(5), 377–392.

Handwerk, M.L., Field, C.E., and Friman, P.C. (2001). The iatrogenic effects of group intervention for antisocial youth: Premature extrapolations? *Journal of Behavioral Education*, 10(4), 223–238.

Knapp, M., Baines, B., Bryson, D., and Lewis, J. (1987). Modelling the initial placement decision for children received into care. *Children and Youth Services Review*, 9, 1–15.

Mech, E.V., Ludy-Dobson, C., and Hulseman, F.S. (1994). Life-skills knowledge: A survey of foster adolescents in three placement settings. *Children and Youth Services Review*, 16(3/4), 181–200.

McMillen et al (2005). Prevalence of Psychiatric Disorders Among Older Youths in the Foster Care System. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(1), 88–95.

U.S. Department of Health and Human Services. (2001). *Youth violence: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

⁴Lyons, J., Woltman, H., Martinovich, Z., and Hancock, B. (2009). An outcomes perspective of the role of residential treatment in the system of care. *Residential Treatment for Children and Youth*, 26(2), 71–91.

⁵U.S. Department of Health and Human Services, Administration on Children, Youth, and Families (2012). Information memorandum on promoting social and emotional well-being for children and youth receiving child welfare services (ACYF-CB-IM-12-04, issuance date 04-17-2012). Downloaded from <https://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf>.

cluding more kin and non-relative foster family placements and more supportive home-and community-based services.

Evidence indicates that children fare best in families. As a recent policy statement by the American Psychological Association noted, “Healthy attachments with a parental figure are necessary for children of all ages and help to reduce problem behaviors and interpersonal difficulties.”⁶

At The Children’s Village, we recognize that children need—indeed have a developmental requirement for—family relationships. We have many dedicated volunteers, talented, caring caseworkers, social workers, supervisors, medical staff, therapists and mental health professionals who make a real difference in each child’s life every day. But they are not family. I am a strong proponent of residential care, because I understand from experience that responsive residential care plays a very important role in our child welfare system—but only as a time-sensitive safety net for the very small percentage of children who are in acute crisis and at risk of harm to themselves or to others.

In the end, we must recognize that help provided by people in the child welfare system, even when it is effective, is only temporary—it *should* be only temporary. Children need stability, understanding, hope, and, most importantly, they need belonging. None of our systems, despite our best intentions and the steadfast commitment of the amazing people who serve alongside me, can provide belonging. Children need adults who stay connected to them over the long haul, through thick and thin. Not a state agency acting as family. Not a child welfare case worker—a committed adult, a place of unconditional belonging and love.

As we say at The Children’s Village, what children need is one willing, stable adult who provides unconditional belonging. We also believe that, if a family or a foster parent cannot provide this unconditional belonging, we must be untiring in creating a family for each individual child.

That means that child-serving agencies, whether they are public agencies or private charities like The Children’s Village, must work closely with children’s families—their parents, grandparents, extended family, foster parents and prospective adoptive parents—to figure out how best to help and support struggling children and families.

In fact, research shows, and the experience of The Children’s Village certainly underscores, that the vast majority of children who must be removed from their homes because of abuse or neglect fare best when living with family—grandparents, relatives or extended family.⁷ Research and our experience also indicates that, in many instances, in-home service models can increase reunification rates—the rates at which children can live successfully with their families after a temporary stay in the child welfare system—and keep children from re-entering foster care.⁸

Even when children need residential treatment, systems need to focus sharply on ensuring that treatment is targeted and brief. Treatment must be customized to the child’s needs. Whenever family is available, treatment must involve family. Research also indicates that the benefits of even the best residential services can pla-

⁶Dozier, M., Kaufman, J., Kobak, R., O’Connor, T.G., Sagi-Schwartz, A., Scott, S., Shaffer, C., Smetana, J., Van IJzendoorn, M.H., and Zeanah, C.H. (2014). Consensus statement on group care for children and adolescents: A statement of policy of the American Orthopsychiatric Association. *American Journal of Orthopsychiatry*, 84(3), 219–225. doi: 10.1037/ort0000005. Retrieved from www.apa.org/pubs/journals/features/ort-0000005.pdf.

⁷Children placed with kin may remain in care longer, but they often have fewer placement changes, experience equal or lower repeat maltreatment rates and experience more of a sense of family than children in other types of foster care. Gleeson, J.P. (2012). What works in kinship care? In P.A. Curtis and G. Alexander (Eds.), *What works in child welfare* (Rev. Ed.) (pp. 193–216). Washington, DC: CWLA Press.

O’Brien, V. (2012). The benefits and challenges of kinship care. *Child Care in Practice*, 18(2), 127–146.

Walsh, W.A. (2013, winter). *Informal kinship care most common out-of-home placement after investigation of child maltreatment* (Fact Sheet No. 24). Durham, NH: 20 Carsey Institute. Retrieved from <http://scholars.unh.edu/cgi/viewcontent.cgi?article=1188&context=carsey>.

⁸Child Welfare Information Gateway. (2011). *Family reunification: What the evidence shows*. Washington, DC: Author. Retrieved from www.childwelfare.gov/pubs/issue-briefs/family_reunification/family_reunification.pdf.

teau⁹—that after they benefit from intensive, evidence-based interventions, children can lose hard-earned gains because they miss their families and feel abandoned, labeled and forgotten.¹⁰ Basically, the longer they stay, even in the best residential care facility, the more children begin to lose hope and regress to risky and self-harmful behavior.

Research indicates that kin and foster families can be found for children of all ages. Many opponents of reform will tell you that we do not have enough foster families to care for children in their custody, especially teens. I would say to those who don't believe foster families are available: It is not easy, but we can do it. We are doing it. In fact, we now know, thanks to research, how to do a much better job of finding kin to care for children. It is time to instill what we know into our child welfare systems, to update practices and significantly enhance our ability to find and support kin who will care for young family members.

We can also do a much better job of recruiting and supporting non-relative foster parents. Let's ask agencies to update their practices to significantly expand their pool of willing and able foster parents. A decade ago, The Children's Village had fewer than 50 foster families. Today, we have almost 400, and many of our foster families are selectively recruited, trained and supported to serve teens. Because of the sacrifice and commitment of these foster parents, hundreds of teenagers have experienced a family and are no longer at risk for long-term system dependence.

How does The Children's Village walk this talk? Not by being perfect. We are not. Not by getting everything right. We don't. We do it by working hard every day to find families for children with even the most challenging histories. Because that's the job of public and private child welfare agencies. Again, it's hard—but it is what our donors expect us to do, it is what we are paid to do, and it is what we believe is right.

Let me tell you about two children in our care. Although he is only 11, Jose has had a difficult life, as have so many children in our care. He had been freed for adoption twice, once by his mother and again when the aunt who had adopted him returned him to the system after a violent incident in her home. In addition, Jose lived for a year with a pre-adoptive family—a relationship that eventually failed. That is a lot of rejection for one child, since termination of parental rights often means a total shutdown in relationships.

By the time he was sent to The Children's Village, Jose's family connections were almost entirely severed. We immediately focused on identifying as many family members as we could. We connected him with more than 10 relatives and family friends, including his birth mother and his siblings. He hadn't seen or heard from them in 5 years. We found a pre-adoptive family willing to build a support team for Jose, help him develop a relationship with his birth family and work toward being adopted.

Then there is Sammy. Sammy's history would give you pause. At age 16, he was placed at The Children's Village because of a history of sexually aggressive behavior that included assaulting his sister, three cousins and a family friend. Sammy also experienced auditory hallucinations and suicidal thoughts. Because he abused his sister, and because of abuse he suffered at the hands of his mother, we needed to find family who could do the hard work of recovery alongside Sammy.

Sammy's paternal grandfather was up to the task. While Sammy was at The Children's Village, his grandfather and he participated in family therapy. They worked in an ongoing Multifamily Group that provided psycho-education.

Then, there was a wrinkle. Sammy's father was in prison and was scheduled to be released to live with Sammy's grandfather at about the same time Sammy would be released from The Children's Village. The family believed Sammy's father, who did not know about Sammy's offenses, could harm Sammy. Sammy and his Children's Village social worker had phone sessions with Sammy's father to disclose information about Sammy's actions, help the father process what had happened, and share evidence that Sammy was growing healthier.

⁹ Lyons, J., Woltman, H., Martinovich, Z., and Hancock, B. (2009). An outcomes perspective of the role of residential treatment in the system of care. *Residential Treatment for Children and Youth*, 26(2), 71–91.

¹⁰ One example: Jackson, D., Keir, S., Ku, J. and Mueller, C. (2012). Length of treatment in CAMHD programs: Using the CAFAS and MTPS assessment instruments for decisions regarding discharge. Retrieved April 29, 2015, <http://hawaii.gov/health/mental-health/camhd/resources/index.html>.

At The Children's Village, Sammy was weaned off his psychotropic medications; he engaged in TV production and other positive activities. Upon his release, he went to live with his grandfather and father and continued to participate in family therapy. It has been a year since he was discharged, and Sammy has not engaged in any delinquent acts nor has he been sexually aggressive or abusive.

These are just two examples of the children that child welfare systems take on every day. While the responsibility we shoulder is immense and our efforts don't always succeed, our success with children like Jose and Sammy bolster my certainty that we can do better by children by meeting their needs, whenever possible, in family settings. If a brief residential stay is necessary, children can improve when family members are closely involved in the child's treatment. In the absence of available family, as in Jose's case, it is incumbent on us to be untiring in our efforts to identify family and/or create a family for each child.

STATE ACTION IS NEEDED

Beyond changing how agencies handle care for children in their custody, what else can be done to ensure that children grow up in families, not in residential care?

This change will require state and local action. To improve how they fare in the long run, children and families must be treated as individuals. That means communities need to know how to assess local needs and develop or install effective programs and interventions to meet those needs. Communities must work across agency silos, with public and private providers like The Children's Village, to build broad, effective service arrays that fit local needs and change as needs change.

Crucially, communities must have sufficient funds, and sufficient public will, to provide needed services. In a national sample, more than one quarter of child welfare directors across the nation reported they had inadequate access to children's substance abuse services; more than a quarter did not have access to needed mental health services for children. Services for parents were insufficient as well, with 37 percent of child welfare directors reporting too little access to adult mental health services and 24 percent noting too little access to substance abuse services for parents.¹¹ We also know that the supports offered to kin, foster and adoptive families, both personal and financial, remain woefully inadequate.

There is another important benefit of reducing inappropriate use of residential care. It frees up dollars that, when managed strategically and with a long-term commitment to re-investing in families, can be invested in effective preventive and supportive services to meet the child and family needs in the community. It would be irresponsible to cut residential care without a systematic and long-term plan for investing in community services.

We are not faced with easy decisions, but I can say with confidence that family and community-based services, in addition to costing less, are most effective for a child. Also, inappropriate long-term residential placement is often personally destructive for children.

What does a broad service array look like? At Children's Village, we now provide a variety of programs that help the city and state of New York meet child and family needs while children live at home. In addition to our committed and effective residential staff who work with teens in acute crisis, our greatest source of pride is our large number of foster families who provide temporary care to some of the oldest teens in the child welfare system. The needs of these foster families, of the kids they parent and of children and parents in the community are met by neighborhood-based programs as varied as classes, support groups, crisis response, food pantries and workshops.

We also offer, in different locations, supportive housing, evidence-based preventive family therapies, family court assistance, community activities, mentoring, even free classes in the humanities. In short, we strive to wrap ourselves around our children and families. We want to be there for them during crises and walk alongside them to celebrate their successes.

Notice that when I mention what states and localities can do to update child welfare practices and policies I reference *effective* programs. I agree with the Children's

¹¹ Casanueva, C., Horne, B., Smith, K., Dolan, M. and Ringeisen, H. (2011). *NSCAW II baseline report: Local agency* (OPRE Report #2011-27g). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Bureau, which has made the case that we should scale down and stop funding programs that don't work.¹² Often, the ability to do that—to shift to more effective approaches—resides within local and state child welfare agencies.

PRIVATE PROVIDERS NEED TO CHANGE THEIR BUSINESS MODELS

State and local agencies also need to better collaborate with private providers to make the changes that are needed. I am often in meetings in which public child welfare systems complain about private providers. They say they can't get the services they need. Or they don't feel they are receiving quality services. This is difficult work that we do together. There are no easy answers, but the only path to an effective solution requires that we work together. My response to state and local agencies is straightforward. Hold us accountable. And invite us into the room when you are making decisions. If you expect us to be innovative, we will be innovative or we will be forced to close our doors.

In fact, the time has come for private providers to make a change in how we do business, and more providers than you might think are rising to this challenge. Just as public agencies must change, so must private agencies. Our business models must move away from mostly residential care and toward community- and family-based care that is targeted, effective and short-term—including, of course, short-term effective residential care as needed for emergency interventions.

You may hear complaints from private providers in your district. They may say this kind of change is hard. Or that the needs of children and families cannot be met using these new models of care. But the evidence is not on their side. And we know that this kind of evolution is challenging to the tradition of “rescuing” children from their families and communities.

For many years, Children's Village was a reform school on a leafy green residential campus. It looks lovely—like a safe place for kids. And it is a safe place for youth to live temporarily to stabilize and be treated.

But leafy green trees do not make a whole child. Belonging and family does. And please remember: Generally speaking, children do not benefit from being miles away from their families. Even when their families are poor or struggling with problems such as addiction. If you help the parents, you help the children—and build a working family. It is time that private providers look beyond our campuses and our inpatient medical models and find effective ways to meet the needs of children while they live with their families or foster families.

If providers complain, it is because the task before us is immensely challenging. It is: I live it every day. But change is required, for the sake of our children. Because we know that in community after community, taxpayers are paying a lot of money to house children away from their families, when significantly better results are possible through well designed, appropriately funded, performance-focused community- and family-based care. Local, state and federal systems need to invest in those services. By doing so, we will also improve the outlook for the economically isolated and often segregated communities where most of our children reside.

A FEDERAL ROLE

The federal government can play a crucial role in moving the nation's child welfare system away from residential care and toward children living in families. Washington can be the catalyst for change by creating incentives and providing real supports for strong systems of community-based care.

How can this be done? Through fiscal mechanisms that incentivize placement of children with families rather than in institutions, and through mechanisms that concurrently invest in supports that allow us to wrap ourselves around the child and family to ensure safety and stability for families. Once implemented, these fiscal incentives should be coupled with limits on residential care for most children.

We believe that, with the right levels of investment in a family driven system, 90 percent of the children in residential care today can be safely cared for in family. To do this means changing the perverse incentives of the current funding methodology. When residential providers get paid by the day for each child, those of us who are successful are penalized financially. Each time we move children toward sta-

¹² U.S. Department of Health and Human Services, Administration on Children, Youth, and Families (2012). Information memorandum on promoting social and emotional well-being for children and youth receiving child welfare services (ACYF-CB-IM-12-04, issuance date 04-17-2012). Downloaded from <https://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf>.

bility and independence by returning them expeditiously to their families or foster/adoptive families, we lose money. This simply has to change in order to do better by children. A financial model that incentivizes safe and expeditious discharge from residential care, with adequate funding to provide the effective community-based support children need, will begin to move us in the right direction.

The federal government can also promote high-quality, cost-effective services that meet children's needs for permanent, loving families and enhance children's well-being. That includes effective prevention services to address needs early. Evidence-based services that support children and families at home. Services to support kin and non-relative foster parents who step up to the plate to care for children. And, for the small number of children who need it, intensive, targeted, evidence-based residential services that involve children's families or create a family as part of their recovery.

None of this will be easy. It is already too late for many in the generation of children languishing in residential care. Their childhoods are lost. But, if we begin now, we can make sure that future generations of children will grow up knowing the love and unconditional belonging of family. That is what it will take to break the intergenerational cycle and system dependence we have experienced for the last four decades.

CONCLUSION

Let me end by sharing one last lesson that The Children's Village has learned. And that is to become educationally proficient, economically productive and socially responsible, children and families cannot be isolated, labeled or vilified. Rather, they must be given hope. They must be encouraged to grow within themselves a sense of belonging—the kind of belonging one can only gain through our connections with family, no matter how imperfect our families may be.

Recently I was at a conference that included a young man—a very extraordinary young man—who had beaten the odds. He had aged out of foster care and gone on to college, as only the smallest number of former foster kids do. He had two important messages about residential care. One was simple. He said, "Group homes lead to broken souls." The other message, I hope, will rally you to action. He said, "We *can* fix this."

Systems are no substitute for family. The children we serve today deserve our urgent action.

PREPARED STATEMENT OF MATTHEW J. REYNELL, ADOPTIVE FATHER OF TWO, AND MEMBER, BOARD OF DIRECTORS, CHILDREN AWAITING PARENTS

Chairman Hatch, Ranking Member Wyden and all members of the Finance Committee thank you for inviting me to testify today on this important topic highlighting ways to safely reduce the overreliance on group and congregate care. My name is Matthew Reynell, and I am from Rochester, NY. I am excited to tell you about my family's story of adoption and the integral role that a residential treatment facility plays in an adopted child's transition from foster care to their "forever" home.

I met my son James on December 31st in 2008. Thanks to the help of a diligent representative at Children Awaiting Parents who was able to locate him and press the case worker to interview us as a potential match. He had just turned 8 years old and was living at Crestwood Children's Center, a residential treatment facility in Rochester, NY. James had been brought into the foster care system 4 years earlier with his siblings. Prior to residing at Crestwood, James had been moved around to several foster homes and schools. The foster parents at his last home had given the promise to adopt all of them together, but later decided that James was too much for them to handle and had him removed. This is how James became separated from his siblings and placed into the treatment facility.

I have always believed that no matter the reason, children should not end up in group homes or congregate care facilities. I viewed them as places where "problem children" were dumped and then forgotten about. After learning that James resided at Crestwood, I became very upset and thought I needed to get him out of that environment as soon as possible. After going through the process of getting to know James through his case workers and treatment team, my attitude and beliefs about this "awful" place were quickly changing. James had been severely neglected and

received minimal schooling prior to arriving into care at Crestwood. James was a child who had always been labeled “the problem kid.” He was the one who didn’t listen like the other children at home or in school. He had a history of outbursts that made people think of him as uncontrollable.

As a child, not only did James have a difficult and grim family history with many of the foundations of early childhood development absent in his young life, he was born with Fetal Alcohol Syndrome (FAS) and suffered severe neglect mentally, physically, and educationally. When he arrived at Crestwood, a treatment team consisting of therapists, psychologists, clinicians, doctors, teachers, and occupational therapists were assigned to him. I learned to view these dedicated individuals as part of James’s extended family and discovered the vital role that this team would play in my life as well. However, I can’t help but think about where James would be if I weren’t identified to be a part of his life, his treatment recovery team and now his proud adoptive father.

The care and attention he received from these amazing people were crucial to his success in moving forward through his heartbreaking and tragic home life that had caused him to mistrust and fear his surroundings as well as the individuals who cared for him to where he could open his heart and truly accept that he was part of a family. I spent 5 months visiting James while he lived at Crestwood, and worked closely with our team. James received the attention he both needed and deserved to be able to start reading and writing, functioning in a home environment, and most importantly, dealing with his past traumas.

Through my experiences with James at Children’s Facility, it is my belief that there needs to be a set timeframe for a child to reside at a treatment facility. Please, if you take anything away from what I’ve shared thus far, please understand that I think Crestwood is the exception, in regards to what youth experience in congregate or residential, rather than the rule. If a child should need any type of residential inpatient therapeutic support, it should be in conjunction with a team of people where the facility is trained to work with and/or identify people who love the child to be a part of the child’s treatment plan. Facilities should be required to have family inclusion policies and they should not be solely focused on their emotional and behavioral issues. These are breeding grounds for failure, because these children have no identified exit strategy. Some people believe that treatment must be sustained and then permanency found and in my experience youth need to feel loved and protected by people who care about them in order to heal from their hurts, *i.e.*, the “behaviors” that landed them in a treatment facility in the first place.

My recommendation is that these facilities be required to have agency policies that support family involvement in the child’s care. In the event a foster child enters one of these facilities, both the agency responsible and the facility protocol needs to include the identification of someone that knows this child and loves this child, and will be dedicated to this child’s safe return from residential treatment. Unfortunately, otherwise, we see the poor outcomes we know and dread: youth sit hopeless, sometime loveless, and almost always miss out on their childhood.

In my case, I had known James for 5 out of the 10 months he had been living at Crestwood, and he had made tremendous progress both mentally and socially during this time. After getting to know James I made the decision to start the process to have him move into my home. But because his transition from residing at Crestwood to living with me was pushed back, as the staff was hesitant to make the move, James started to regress back to old behaviors due to his fears of both disappointment and abandonment. I believe that James wanted to test us and see if we were going to stick it out with him—justifiably so given all he had been through. One time after one of our nightly phone calls, a ritual that James grew to anticipate daily and looked forward to, he called 911 and asked that he be taken to my home out of desperation and fear that I was not going to follow through on my promises to him. We both knew that we needed to take the next step and bring him to my house—his “forever” home.

After moving into our home, James and I were still able to keep our team through Crestwood. We needed this support; it was vital to James’ continued recovery and our family transition. By having the same therapists, doctors, and other professionals who knew of James’ history, it made his transition into his new surroundings easier. We had already established bonds with these individuals that reinforced our feelings of trust and security. Our family was now able to continue to receive many of the same services from the people we already knew, and more importantly, James felt safe with. Again, this should be the norm and not the exception; I’ll stress that continuity in care and trained providers go such a long way for

children who have experienced trauma and foster care, it also gives us parents the tools needed to respond when triggers and stressors come up for our kids.

Our aim and dream for all children in the foster care system should always be to find each child the love and security of a “forever” family, when they cannot safely return home to their own. Now having gone through this process, I understand and believe that to reach this goal may require the intervention of a residential treatment facility and the services that it can provide to both the child and the adoptive parents. We need to have the group home staff; counties and others involved with the child’s case all working collectively towards the goal of a forever family. I believe residential treatment is something that is sometimes needed for children, but we can’t get the outcomes we desire if they are set up only to treat the child, and not include or support parents and caretakers to assist in the healing of these children.

I’ll conclude with remembering a conversation James and I frequently had when he was little. We used to sing along in the car to what was popular on the radio at the time. After our singing sessions I always asked, “James, what am I going to do with you, silly boy?” And James replied, changing the mood just slightly with his tone, still partly jovial but also very serious, he said, “Keep me please, Daddy!” And I did. It is still the best decision I ever made.

To summarize:

- These facilities should always be trying to identify a permanent home resource.
- Facilities should be required to have family inclusion policies and they should not be solely focused on the child’s emotional and behavioral issues, but the family as a unit.
- Continuity in care and support to families is vital.
- Adoption and foster care competent trained providers goes such a long way for children who have experienced trauma.
- The facility staff and case workers should have a planned timeline in which to find an adoptive family for the children who are freed.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

WASHINGTON—Senate Finance Committee Ranking Member Ron Wyden (D-Ore.) delivered the following statement at a hearing to discuss how to safely reduce reliance on foster care group homes:

Thank you Chairman Hatch. You have been a real leader on this topic, and I’m grateful for that.

As the title of this hearing suggests, foster care group homes are “no place to grow up.”

There’s no question that residential care can play a crucial role in the foster care system. But there is wide consensus that children and youth, especially young children, are best served in a family setting. Stays in residential care should be based on the child’s specialized behavioral and mental health needs or a child’s clinical disabilities. They should be used only for as long as necessary to stabilize the child or youth before returning to a family setting.

This notion is catching on. Over the last decade, states have cut by over one-third the number of children living in congregate care. However, there has been wide variation in states’ success in this area—with some even increasing their use of congregate care over the last decade.

To further reduce residential foster care, the conversation must focus on transforming the old group home model into one that is nimble and flexible—able to meet the needs of each child and family rather than forcing an inappropriate and ineffective one-size-fits-all approach.

As this committee will hear today, this transformation is possible, even within the current lopsided funding system. But, the federal government can make innovation much easier by providing greater flexibility in the use of title IV-E foster care funds—flexibility that accepts the reality that there is no single approach that will work for each and every child and family.

To spur these innovations, more information and more ideas are needed. That's why this hearing is so important and why we need to hear from today's witnesses about their on-the-ground experiences with congregate care. I'm especially grateful to Associate Commissioner Chang for coming to discuss the Administration's proposal to reduce the use of these settings.

I'd like to make three observations on this topic. First, there's no question that high quality, residential care plays a crucial role in the foster care continuum. But at the same time, it's clear that not everybody's on the same page when we talk about congregate care. The terms "congregate care," "group homes" and "residential treatment" are often used interchangeably; but the structure and quality of these settings varies widely as our witnesses will show.

Second, it's important that the discussion over safely reducing congregate care commensurately focuses on building the capacity for foster parents, kin, adoptive parents and entire communities to care for children in family settings.

And third, the best way to reduce reliance on congregate care is to prevent children from entering foster care at all. For decades lawmakers, practitioners and advocates have talked about the need to provide support and prevention services for children and families in crisis. These investments can help keep children safe in their homes or with other family members while reducing the need for costly and traumatic transfers to the foster care system.

For this reason, I've drafted legislation to reform the foster care finance structure to give states and tribes the ability to use federal dollars that are now reserved only for foster care placements to finance new tools to keep families together.

It's time to consider new approaches, new ways of funding, and new ways of thinking that serve the goal we all want—ensuring all kids grow up in healthy, nurturing, and safe environments.

It's no understatement to say children are counting on us to get this right. I look forward to working with you, Chairman Hatch, my colleagues, and others to make sure we accomplish this goal.

COMMUNICATIONS

Alliance for Strong Families and Communities

1020 19th Street N.W., suite 500
Washington, DC 20036

Statement for United States Senate Committee on Finance hearing:

“No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes”

May 19, 2015

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A network of more than 400 nonprofit human-serving organizations nationwide, the Alliance for Strong Families and Communities is dedicated to achieving a vision of a healthy society and strong communities for all children, adults and families. The Alliance network is the largest membership of provider organizations in the country, and thus represents a crucial voice in child welfare reform. We lead our members to engage in improving opportunity for children and families, and encourage them to play an active role in strengthening our child welfare system. Our members work on the frontlines of child welfare issues and bring powerful experiences to the goal of supporting the very policies and practices through which they can act in the best interest of children and youth to connect them with safe, secure families and permanent homes.

We appreciate the opportunity to share our sector's voice in discussions around residential care and its role in the child welfare continuum of care. At the recent congressional hearing, “No Place to Grow Up,” we heard personal testimonies from youth, families, and providers, discussing the crucial importance of family connections in helping children and families in crisis get back on the path to success, including Alliance board member Jeremy Kohomban of The Children's Village. We wholeheartedly agree with statements emphasizing that residential settings should not be long-term solutions for children. Indeed, residential settings should be used as treatments, essential to a child's well-being, and not as placements at all. A residential setting as a placement is an outdated model, which evidence and experience clearly shows are not in a child's best interest.

Alliance member organizations are leading the transformation of the sector from primarily residential to one that must be home and community based. In fact, a cohort of Alliance members that have successfully made that transition is currently mentoring their peers through the same process. We know from experience that this transformation can be difficult for the systems, providers, and even the individual

children and families involved. Therefore, we are quite concerned by the rhetoric and policy proposals that paint residential as uniformly bad for children, or seek to make it difficult for systems to place children in residential settings. When needed for crisis, stabilization, or other reasons deemed clinically necessary, these placements must be accessible, or some of our most vulnerable children will be hurt. High-quality, child-focused residential care is a critical part of our country's system of care for some children in the child welfare system.

We must not go too far in our restriction of residential care. Policy solutions need to focus on eliminating residential care that is of poor quality or that is used for the wrong reasons. Anything else risks artificially reducing the supply of services and forcing children into settings that cannot meet their most critical needs. We urge policy makers to remember the dissolution of our institutions of mental health. Though it was the right and important decision, it was done without ensuring the adequate supply of alternate care settings, and led to significant increases in homelessness for our nations mentally ill. As we now contemplate limiting inappropriate residential care, we must be sure to provide appropriate alternatives, be they foster care, guardianship, or reunification. Limitations on one form of supply must come with help to states that will ensure parallel increases in other, preferable settings.

The Alliance for Strong Families and Communities urges lawmakers and advocates to remember that the needs of children and families should always be our number one priority. At every decision point on a child's stay in the child welfare system, decisions about their care must be made by caring, clinically trained individuals with first-hand knowledge of their individual needs. To get there, we need two things:

First we need a validated capacity plan by state, much like hospitals now use, based on utilization, population trends and projections, so we know how many residential beds the children's behavioral health system needs, where they are needed and by what type and quality. We also need to understand that to move our country forward we must employ a more flexible federal financing model that allows states to create more homes and community based behavioral health services and family supports, find more relatives to care for kids, recruit and support more foster families and modernize child protection systems for the 21st century. Quality, evidence based residential treatments are essential and serve as a critical part of the community based system of care, and should not be artificially limited through time or age limits or made bureaucratically difficult through procedural barriers.

Our network of members encompasses a change agent that is moving our country forward. We know that this will not be easy and we know that it requires transformation in our thinking, our policies and our practices. But if we, as a country, can commit to making a strong investment in the tools and resources needed, we are confident that we will be successful in our mutual goal of lifting up children and families facing crisis, as well as helping to promote safety, permanency and improved well-being for all children who are served by the child welfare system.

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Kari Sisson, Executive Director

May 29, 2015

U.S. Senate Committee on Finance
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Members of the Senate Finance Committee:

The American Association of Children's Residential Centers (AACRC) is a national membership organization with members across the United States dedicated to providing high-quality therapeutic interventions to children and adolescents with mental and behavioral health challenges. Our members serve the individual needs of youth and families in a range of settings—in the home and community as well as in schools and residential treatment programs. We are the longest standing national association focused exclusively on the needs of children and families in need of residential interventions and our members are keenly focused on evolving quality programming that implements evidence-based practices to achieve positive outcomes for children and youth.

Over the past decade, our membership has worked to achieve the highest standards in providing care to youth in residential treatment by seeking continuous improvement in the provision of care to respond to the changing treatment needs and care requirements of some of the nation's most vulnerable children. AACRC members have authored a series of "Redefining Residential" papers¹ that instruct and emphasize the importance of best practice service delivery including family-driven, youth-guided care, community-integrated and trauma-informed care. As a result, today's residential providers work with youth, parents, and extended family as equal partners in identifying needs and developing the individualized services and supports that are essential to help youth and families recover from adversity and trauma.

AACRC has also worked closely with the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Building Bridges Initiative (BBI) to affirm and better integrate residential treatment as a key element of the continuum in community systems of care, and has developed standards, characteristics, and research to support the refinement of programs. Guided by a steering committee inclusive of national youth and family associations (Federation of Families for Children's Mental Health, YouthMOVE), Georgetown National Technical Assistance Center, major associations that have residential members (AACRC, National Council for Community Behavioral Health, Child Welfare League of America, Alliance for Strong Families and Communities, National Association for Children's Behavioral Health), BBI has engaged policymakers at the state and national level, as well as providers, in the effort to transform and integrate comprehensive community systems inclusive of all levels of response a child and family might need.

BBI sought to address a long-standing tension that drives a wedge between community-based resources and out of home resources that is the subject of this hearing. This tension is due to several factors arising from a shortage of financial resources and at times a misunderstanding of how each level of care contributes to the continuum that a youth and family may need based on the acute nature of their mental health needs. BBI resulted in an advanced understanding of each of the elements of an effective continuum of care for children and families. From this framework, the initiative developed standards for each level of care in the continuum, including residential treatment. The initiative findings, recommendations and standards are available online.² Additionally a recently published book³ contains a wealth of strategies that have been successful in programs around the country and is an invaluable resource for program and system change.

The AACRC membership and broader child welfare field have responded to these initiatives and innovations by integrating a host of evidence-based and research-informed strategies to teach coping, relational and cognitive skills to support youth in recovering from trauma, while also providing academic, vocational, and independent living supports to help youth function successfully in home and community settings, and achieve permanency. Through these efforts, residential treatment programs have become highly sophisticated in their response to the evolving best practice and the acute mental health and behavioral needs of youth, and are achieving a range of successes, including improving outcomes, providing a positive and safe experience for youth and families, shortening lengths of stay, and achieving timely and sustainable permanency.

Current Role of Residential Care

As these many efforts make clear, AACRC supports the Committee's commitment to the appropriate use of residential treatment and shares the goal of ensuring that children and youth live in the least restrictive, most family-like settings whenever

¹http://www.aacrc-dc.org/public_policy.

²<http://www.buildingbridges4youth.org>.

³"Residential Interventions for Children, Youth, and Families: A Best Practice Guide," ed. Gary M. Blau, Beth Caldwell, and Robert E. Lieberman, June 2014.

possible. We write today to ensure that the Committee deliberates strategies to advance these goals in full consideration of an accurate understanding of the current use of residential care and the needs of children placed in residential treatment programs.

Research from the Centers for Disease Control shows that 90% of youth in the foster care system have experienced multiple adverse childhood experiences (ACE), increasing their risk for a range of struggles, including substance abuse, academic delays, runaway behaviors and episodes of homelessness, early pregnancy, and involvement with the criminal justice system. Youth with these challenges not only require significant supervision to ensure their safety, but also the support of highly qualified staff and research or evidence based residential interventions to address their complex needs and help them safely stabilize, improve their functioning, and ultimately improve outcomes. In addition, youth need support in developing a healthy system of supports in the community to help them maintain positive outcomes over time and achieve permanency. When it comes to residential treatment, youth with such complex needs are not at all the exception, but rather represent the typical population served in residential treatment centers. Undoubtedly, there are cases in which youth with lesser challenges are placed in residential settings by child welfare agencies, but those, in fact, are the exceptions.

Unfortunately, due to the higher cost associated with group home and residential care, youth are often placed in these services only after being bounced among placements in other forms of care, often when past assessments had indicated a need for a higher level of care months or years earlier. Thus, rather than utilizing residential care when a child first demonstrates a clear need for that intervention, youth frequently continue to be placed in less restrictive levels of care. It is often only after they have suffered further trauma due to insufficient services and placement disruptions that they are placed in residential settings where levels of supervision and support are equal to their needs.

As a result, residential settings must bear the burden and address the challenges associated with youth traumatized by earlier insufficient levels of care. We know that children with multiple foster placements and/or who age out of the foster system tend to not do well later in life. Instead, outcomes are improved when children are placed in the correct treatment setting at the earliest and most appropriate time. In addition, research clearly indicates that children in congregate care achieve better outcomes depending on the degree of family engagement and participation; that is, when their families are supported in developing the skills to address trauma and provide stable and healthy homes. As Mr. Reynell's testimony demonstrated, residential services play a critical role not only in stabilization but also in ensuring long-term permanency for children and families.

Concerns About Recent Proposals

We believe there are a number of practical and rational approaches to meeting the laudable goal of improving outcomes for youth in the foster care system, from bolstering the capacity of families and communities to identify and serve children with intensive needs, to increasing federal oversight to ensure that states are being held accountable for undertaking appropriate efforts to prevent the unnecessary placement of children into group homes. We were particularly struck by Ms. Gruber's testimony and the failure of the system to respond to her ability and right to live with her extended family or in another less-restrictive setting. Our organization is eager to support the Committee in its work, and has the organizational capacity to support the development of effective policy and strategies to prevent the recurrence of Ms. Gruber's experience. However, we are concerned that certain policy proposals under consideration will have significant unintended consequences that can negatively impact the achievement of this goal, challenge the ability of state and local systems to support children with the most intensive needs, and have adverse effects on the children and families in our communities. Our concerns are outlined below.

Definitional confusion: Group care is not well defined in the current system, with over 100 references in literature and federal policy to various types of residential and congregate care. Too often all types of congregate care are treated as equivalent, from single-site, family or faith-based group homes to sophisticated intensive psychiatrically oriented treatment settings. These definitional ambiguities can lead to misinterpretations of legislative intent and poor matching between programs and identified needs, unintentionally denying children the services and supports that they need. Previous proposals considered by the Committee (including S. 1518) have shared this flaw, failing to differentiate "group homes" from quality residential treatment, conflating these into the "congregate care" category. While we under-

stand that the intent is to prevent unnecessary congregate placements for children and youth like Ms. Gruber whose needs can be met in the community, the proposed approach would limit the ability to provide residential interventions to children and adolescents with acute and complex mental and behavioral health challenges. While previous proposals built in exemptions from the time limits for some subsets of children and youth, including those with severe physical disabilities, they did not exempt children and adolescents with mental or behavior health problems, who represent the majority of those needing residential interventions and who are entitled to this treatment by existing parity laws.

Arbitrary timeframes: Legislation introduced in the previous Congress (S. 1518) proposed limiting federal Title IV-E reimbursement for children under age 13 placed in a broadly defined category of “congregate care” after just 15 days. For those over 13, federal funding would be cut off after 12 months of continuous care (and/or 18 months of non-continuous care). We expect this proposal to be reintroduced this year and most likely discussed at tomorrow’s hearing. While time limits may create a sense of urgency for child welfare workers in communities across the country to work toward family reunification, they also can create perverse incentives. They establish arbitrary metrics that are not based on the immediate need of the child or the immediate ability of the family to respond to those needs, and are inconsistent with a commitment to addressing the diverse and unique challenges and needs of children in foster care. They are also not sensitive to the variety of stressors over the course of a child’s life that can result in out of home placements that can accumulate to the limits being met before safe and permanent family resources can be put into place. While we recognize and share the desire to reduce lengths of stay and our members havemade great strides in doing so, the reality is that some highly traumatized children with acute mental health needs will require longer courses of treatment than are supported by these timeframes.

Insufficient family based alternatives: Resources to support families remain inadequate to meet the growing need across the country. As poverty and its concomitant stresses increase, supports that can help a family respond effectively to the needs of its children are often sparse and poorly matched to individual needs. While in-home and community based programs are productive, service arrays across the country are not currently robust enough to ensure that children with the most acute needs will be adequately supported. Families are thus often able to access few resources to respond to the very real crises they and their children face. Furthermore, the infrastructure is not currently sufficient to absorb children turned out from congregate care and very few community-based programs have any evidence of consistent success in addressing the acute mental health needs of highly traumatized children with poor family supports. While we certainly support developing and expanding these approaches, it will take considerable time and resources, and if we simply de-fund currently available, proven programs, we risk creating a sub-generation of children and families left to suffer the poor life-long outcomes associated with trauma and unmet needs.

Indeed, recent examples from other countries highlight the negative impacts of eliminating access to residential treatment. In the 1980s, Warwickshire County, England closed down all of its residential treatment facilities, only to see increased placement disruptions, less family connectedness, reduced permanency, worse educational outcomes, higher levels of emergency medical admissions and juvenile justice involvement, and, tellingly, the placement of many youth in residential programs in other counties.⁴ Australia implemented a similar policy in the 1990s and found that closing residential facilities overburdened the foster care system and resulted in increased youth homelessness and involvement with the juvenile justice system, which ultimately increased taxpayer costs. Ten years later they found themselves needing to reestablish residential treatment capacity, but without the advantage of the expertise that had previously been in place and that could have been built upon.⁵ A number of important lessons can be learned from these experiences, including simply limiting the options available to support youth with serious mental or behavioral health challenges without first establishing a proven set of alternative supports in the community is likely simply resigning ourselves to worse outcomes. Failing to address youth’s needs all but ensures that they will end up disconnected

⁴ Cliffe D, Berridge D. Closing children’s homes: An end to residential childcare? 1992. London, National Children’s Bureau.

⁵ Ainsworth F, Hansen P. A dream come true—no more residential care: A corrective note. International journal of Social Welfare 2005; 14: 195–199.

from society, leading to increased criminal behavior and reliant on homeless shelters, hospitals, and prisons.

Cost shifts and impact on Medicaid: We are also concerned that limiting IV–E reimbursement for residential treatment will result in shifting costs to the states that continue to be responsible for responding to the immediate needs of children and families. This would undoubtedly have the effect of causing states to prioritize cost-saving over the individual needs of children and families, likely eroding the quality of care provided in residential interventions and resulting in the early discharge of children and adolescents before treatment is complete. Prematurely returning young people with mental and behavioral health challenges to communities absent a robust system of care is essentially forcing them to rely on the resources that had previously proven inadequate to their needs. This will extend the progressive impact of adversity that has been shown in research to guarantee poor outcomes for these children and youth, including increased homelessness, victimization, hospitalization, and incarceration, all of which ultimately have very significant costs to government.

Furthermore, limiting IV–E reimbursement is likely to simply shift costs to Title XIX, increasing the demand on Medicaid. As Medicaid authorizes services based on medical necessity, if foster youth are reliant solely on Medicaid programs to receive adequate care, we’d expect to see an expansion of diagnosis, potentially unnecessarily stigmatizing children who have already experienced significant stress and trauma in their lives. A further consequence of a shift to Title XIX would be to strain the availability of rehabilitation options to provide funding for Wraparound services, shown to help support and restore families, and an essential foundation for the development of community based alternatives.

The need for new investment: Recent research conducted by Yale University and The University of Southern California indicates that child maltreatment is significantly more prevalent than previously understood, with one in every eight American children being substantiated as a victim of abuse or neglect by age 18.⁶ Not only is the scope of the problem much larger than we thought, it’s impact is profound. According to the CDC, adverse childhood experiences are the leading determinant of negative social and physical health outcome in the United States, including early death.⁷ The CDC has identified this research, replicated repeatedly across the country over the past 17 years, to equal or exceed the most robust epidemiological data it has gathered; its researchers term adverse childhood experiences “the smoking gun”—the most major public health problem we face as a nation. We also have in-depth understanding of the progressive impact of adversity from childhood into adulthood, and that it cuts across the full range of social problems that we face. Emerging knowledge in the domain of neuroscience sheds light on how trauma affects the brain, thus impacting to every aspect of development and life trajectory.⁸ When a public health challenge has this level of predictability, it creates an ethical imperative to create interventions that will mitigate or reverse negative outcomes and yield significant societal and fiscal improvements that will vastly outweigh any up-front, short-term cost.

This knowledge creates a responsibility as a nation to not short change our future, in this case our children and the families raising them. A return on investment approach, involving strategic and targeted investment in interventions shown to be effective, with rigorous accountability provisions, would afford our society the opportunity to address this most difficult and challenging issue. This would avoid the “robbing Peter to pay Paul” potential of budget neutrality and promise a robust system ranging from prevention and family preservation supports and services up through the most intensive interventions. Done thoughtfully and accountably, relatively small investments in the scope of the national budget can yield disproportionately large effects.

Precedent setting: Lastly, we are concerned that imposing time limits on residential treatment for foster children sets a dangerous precedent and ultimately endangers federal funding for other forms of out-of-home care, including family-based foster care. None of us wants any child to spend a day longer away from home than is necessary, but foster care is nonetheless an essential part of the safety net for

⁶Wildeman C, Emanuel N, Leventhal JM, Putnam-Hornstein E, Waldfogel J, Lee H. The Prevalence of Confirmed Maltreatment Among US Children, 2004 to 2011. *JAMA Pediatr.* 2014;168(8):706–713. doi:10.1001/jama.pediatrics.2014.410.

⁷CITE.

⁸CITE.

children and families. Stays in foster care are not only about providing a short-term substitute family, but also about treating the significant emotional, social, and behavioral challenges created by severe trauma. Addressing these needs requires intensive support over time. We all wish that children did not suffer from maltreatment, neglect, horrific abuse and then face a wide range of physical, mental, emotional, and behavioral challenges. But it happens far too often and requires a comprehensive and adaptable continuum of care capable of providing them with the services and supports they need. Their families similarly need recourse to an extensive and diverse array of services and supports if they are to recover, restore their families, and confidently provide the care their children need. Restricting the child welfare system's ability to serve those with the most acute needs is simply resigning them and their families to unacceptable outcomes.

Better Alternatives

Fortunately, there are other more promising current proposals for how to reduce unnecessary utilization of congregate settings while facilitating the development of community-based resources. In his Fiscal Year 2016 (FY 2016) Budget, President Obama proposes a two-tiered approach involving enhanced federal oversight of states and increased federal funding to support alternative placements for children who can be served in the community. The President's proposal recognizes that given the diverse needs of children in foster care, there cannot be a one-size-fits-all approach.

Specifically, President Obama's plan would require a documented assessment justifying why any child is placed in congregate care. In addition, it would require a judicial determination to be made after a child has been in a congregate care setting for 6 months (and every subsequent 6 months) confirming the appropriateness of the placement to meeting the child's needs and documenting the progress that is being made in transitioning the child to a more family-like setting. Crucially, though, the President recognizes the need to concurrently bolster the ability of other settings to meet children's needs, and would provide new funding through IV-E to support capacity building in the community, including specialized case management, expansion of therapeutic foster care, and reimbursement for daily supervision of children who are in need of specialized services.

Additionally, Senator Ron Wyden (D-OR) has drafted legislation that would bolster funding for prevention and services to families. It cites state and tribal innovations implemented through Title IV-E Waivers to suggest that investing in front-end prevention and family services can help reduce the prevalence of foster care. This would in turn reduce the need for residential interventions. Wyden's bill would provide for a host of time-limited family services and supports, including parent training and mentoring, counseling, trauma-informed care, crisis intervention services and assistance, and other evidence supported interventions. This approach seeks to create the healthy infrastructure of services and supports in communities and provide evidence that these services can over time achieve the goal of the Committee and reduce reliance on group homes/residential treatment, without the danger of creating the immediate gaps that would occur from the imposition of arbitrary time limits.

In conclusion, AACRC applauds the Senate Finance Committee for its dedication to preventing states from placing children and youth in group care whenever their needs can be met in a family or community setting. We appreciate your leadership in elevating these conversations, and trust that you will ground your consideration of specific policy proposals in an understanding of the complex needs of children and families, and the reasons why quality residential interventions have an essential role in the continuum of care for foster children. Our membership shares your objectives and is committed to working with you to craft workable policies that will hold states accountable and develop viable alternatives while also preserving the entitlement to residential interventions for children and adolescents in need of intensive care.

Thank you for the opportunity to submit this statement for the record.

Sincerely,

Kari Sisson

Executive Director

American Association of Children's Residential Centers (AACRC)

The Annie E. Casey Foundation

Every Kid Needs a Family

Statement Submitted to the Senate Finance Committee

May 19, 2015

By Patrick McCarthy

President and CEO, The Annie E. Casey Foundation

701 St. Paul Street
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The Annie E. Casey Foundation appreciates the opportunity to submit written testimony for today's hearing, "No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes," on the important subject of where children should live when they have been temporarily removed from their homes by our child welfare systems. As we explain in a new KIDS COUNT® policy report called *Every Kid Needs a Family: Giving Children in the Child Welfare System the Best Chance for Success*, every kid needs a family to nurture and support his healthy development during the fleeting and critically important years of growing up.

Research shows that families are essential to children's healthy development—and that even children who cannot live with their own parents because of abuse and neglect can develop nurturing, beneficial relationships with relatives, close family friends or caring foster parents who step in as caregivers. These relationships make a big difference in a child's ultimate path in life. Young people who grow up in families do better in school, are more likely to graduate from high school and are less likely to be arrested than those who grow up in group placements.

While federal law has long required that children in the child welfare system live in the least restrictive placement possible—the setting most like a family—more than one in seven children removed from home lives in a group placement, not a family. For teenagers in the system, the number is one in three. What's more, a recent U.S. Department of Health and Human Services report, *A National Look at the Use of Congregate Care in Child Welfare*, found that more than 40 percent of young people in group placements had no mental health diagnosis, medical need or behavioral problem that might warrant such a restrictive setting, and that still others could live in families with the right services. While residential treatment is a beneficial, short-term option for the small percentage of young people whose clinical needs can't be met in a home setting, its goal should be to help kids heal and prepare them to return to live safely in a family as soon as possible.

As the data in the Casey Foundation's policy report and the HHS report show, states have been making progress in placing more children in families. But this progress is inconsistent among and sometimes even within states, and we know still more progress can be made. Policymakers at the federal, state and local levels, along with child welfare agency leaders and judges, can make changes in policies and practices that enable more young people to live in families during their transitional time in child welfare.

The Casey Foundation's report outlines recommendations for these changes in three main areas:

- **Expand the service array to ensure that children remain in families.** Communities that provide a broader range of services have more options that enable children to remain safely in families, including returning home to their own parents if appropriate.
- **Recruit, strengthen and retain more relative and foster families.** Child welfare agencies should exhaust all means to find available kin and remove barriers that would keep kin from being licensed and financially supported as foster parents. In addition, engaging and equipping caring foster families—including increased investments in foster parent recruitment, licensing and support to maintain a robust census of available beds for emergencies and children with complex needs—should be a top priority for states.
- **Support decision making that ensures the least restrictive placements.** Policymakers, public agency leaders and the courts should require substantial justification for more restrictive placements, as envisioned in federal law.

In addition to these recommendations from the Casey Foundation's policy report, which can be downloaded at www.aecf.org, Casey has proposed ways to restructure

federal child welfare financing to promote best practices that help more kids grow up in families. Also, the Foundation has captured success stories from jurisdictions that have made deliberate efforts to increase family placements. In particular, I commend to your attention the following resources:

- *When Child Welfare Works: A Proposal to Finance Best Practices*. This policy proposal outlines recommendations for strategic reinvestments of federal dollars that can encourage states to adopt best practices, including the placement of children in families. An accompanying infographic, *The Cost of Doing Nothing*, shows how federal funding streams for state child welfare systems will continue to decline without restructuring of the outdated financing system.
- *Too Many Teens: Preventing Unnecessary Out-of Home Placements*. Too often, teenagers enter the child welfare system because they simply aren't getting along with their parents. This paper traces the Foundation's efforts to learn from communities that are preventing teens from landing in the system by helping families while the teen remains at home.
- *The Connecticut Turnaround: Case Study*. Over 5 years, Connecticut has made substantial progress in reducing the number of unnecessary child removals and ensured that children entering state custody live in families whenever possible, not in group placements. This report presents the new policies and practices that have led to this turnaround, including a focus on kin.
- *10 Practices: A Child Welfare Leader's Desk Guide to Building a High-Performing Agency*. This guide outlines best practices for child welfare leaders and offers tools for measuring improvement.

As these examples and recommendations show, positive change is within in our grasp—and children are depending on us to deliver. Thank you for your attention to this issue.

Children Awaiting Parents

Waiting Foster Youth Linger in Residential Treatment

Statement for inclusion in the hearing record:

"No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes"
Hearing held on May 19, 2015

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May 19, 2015

Introduction

Older children that have been legally freed for adoption in the United States are a hidden and vulnerable population. Some of the current child welfare practices are inadvertently preventing them from finding a timely connection with a permanent, forever family. Working as a Wendy's Wonderful Kids (WWK) Recruiter at Children Awaiting Parents in Rochester, NY from 2008–2013, I had a unique perspective on "the system." To me, "the system" was made up of caring social workers all trying to help foster youth, but never able to replicate the life-long stability of a permanent family. I believe part of the reason waiting youth remain hidden in foster care is a result of prolonged stays in group homes where they are isolated and unable to form new connections with permanent families.

Children Awaiting Parents (CAP) is a private, non-profit organization that has been committed to finding families for waiting foster youth for 43 years. CAP's mission is to find adoptive families across the United States for youth who are in the greatest danger of aging out of the foster care system. CAP's waiting children are often older, minorities, sibling groups who wish to be placed together, or children with emotional, mental and/or physical disabilities—children who are typically categorized as "special needs," "hardest to place" or even to some, "unadoptable." CAP's national photolisting has brought awareness to the need for families and helped 6,000 youth find permanent homes. As a private organization, CAP has the ability

to advocate for children and families who often “fall through the cracks” of the child welfare system.

During my time as a WWK Recruiter at CAP, I worked with 50 of the “hardest to place” youth in the Western New York area from 8 different counties. About 40% of these youth were in congregate care settings and the rest were in temporary foster homes. My job was to implement the WWK Recruitment model that’s effectiveness has been proven nationally. Through grants from the Dave Thomas Foundation for Adoption, over 200 WWK recruiters are stationed at child welfare agencies across the country. WWK recruiters find adoptive homes for a small caseload of waiting youth. The Dave Thomas Foundation has found that children over the age of 15 in the WWK program are up to three times more likely to be adopted than youth not served by the program.¹ The program achieves success by employing a worker whose sole purpose is to advocate that adoption be pursued for each youth on their caseload. As part of the WWK program, I met with foster children monthly to build a relationship with them, I reached out to birth family members who may be able to adopt, advocated for adoption and implemented child-specific recruitment within their network of county workers, therapists, group home staff and educators. I found that many of the children on my caseload seemed to get “stuck” in congregate care longer than necessary. Their stay in congregate care lengthened their stay in foster care and in some cases, they became “institutionalized” making it very difficult for them to ever function in a family setting.

Even though congregate care can be effective in teaching family-appropriate behavior, children who are freed for adoption need a different approach. Usually children with behavioral or mental health problems are admitted to group homes for a specific amount of time to complete treatment, when treatment is finished (as proven by their behaviors) they return home. However, children who do not have a home to return to may enter into a cycle of performing the tasks they need to be released, only to find that there is no home available at the time, getting discouraged and falling into old behavioral or mental health patterns and then having to start over. These children may never seem “ready” for a family, but we have to remember that a family can function as part of their lifelong “treatment” and be part of what is needed to provide true healing. Children who have been permanently removed from their family of origin and suffered abuse, neglect and years of loss, need more than group home treatment to help them cope. They need and deserve every opportunity at stability and connectedness we can offer them—especially a family.

The Problem: Foster Youth Linger in Congregate Care Facilities

Statistics

According to the U.S. Children’s Bureau, there are approximately 402,378 children in foster care in the United States. Out of those 402,378 children in foster care, 101,840 have had their parental rights terminated and are waiting to be adopted. The need for permanent, loving families for those thousands of waiting children is great. Children who are waiting to be adopted are either living in non-relative, temporary foster homes, kinship foster homes, group homes or residential treatment facilities. Many children linger in foster care for years and eventually age out at age 18 or 21. According to the 2009 AFCARS report posted on the Children’s Bureau website, 11% of children currently in foster care have spent 5 years or more in care (48,088 children), 12% or 49,122 children have spent 3–4 years in care, 5% have spent 30–35 months in care, 7% have spent 24–29 months in care, 9% have spent 18–23 months in care, 13% spend 12–17 months in care, 18% have spent 6–11 months in care, 19% have spent 1–5 months in care and 5% have spent less than one month in care. The average length of time U.S. children spend in foster care in 2009 was 26.7 months and the median was 15.4 months. According to a recent 2015 Children’s Bureau report, the overall time in foster care is longer for children who spent time in congregate care, with an average of 28 months compared to 21 months total time in foster care. Some children have spent upwards of 10 years in foster care without a permanent, loving family connection.

¹ Child Trends, “Dave Thomas Foundation for Adoption: A national evaluation of Wendy’s Wonderful Kids” <https://www.davethomasfoundation.org/about-foster-care-adoption/research/read-the-research/fact-sheet/>.

Negative Outcomes of Prolonged Foster Care and Residential Treatment

Without caring, committed families to advocate for them, foster youth may unnecessarily linger in group homes or congregate care facilities. "Nationally, about one fifth of children in foster care are in congregate care settings," Freundlich and Avery (2005). AFCARS reports that 16% of children in foster care or 65,804 children were placed in a group home or residential treatment facility in 2009.

Youth in foster care who are freed for adoption are at risk for a multitude of problems. They may bounce around from home to home, never establishing permanency. They may fall into some of the same patterns of their birth family: teen pregnancy, poverty, drug use, incarceration, etc. "Studies from around the country show that a disproportionately large number of post-foster care young people do not receive high school degrees, do not have jobs, or are dependent on welfare, become homeless, become involved in the criminal justice system, and suffer health problems," Youth Advocacy Center (2001).

The risk level for foster children is compounded if they are in a group home or residential treatment facility, as opposed to a family setting. In a group home, foster children are unable to form lasting connections with adults who may be able to adopt them as part of their family (Freundlich and Avery, 2005). Foster children are also at risk for being over-medicated, becoming institutionalized, being subject to unfair treatment, being victimized by other residents or staff, receiving poor education and not being prepared for life after foster care. "Many group homes and residential treatment centers (RTC's) view control of teens and behavior management as the main priority. This leads to practices that range from absurdly counter-productive through harmful to clearly illegal," Youth Advocacy Center (2001). In a 2003 Children's Rights study, Freundlich found that: in general congregate care does not meet the permanency needs of youth, the quality of staff at congregate care facilities is frequently quite poor, there is a lack of focus on education and mental health treatment, youth are often unsafe because of peer violence, inadequate attention is given to identifying extended family members or caring adults who could be permanent resources for the youth, youth are not involved in planning for their future, youth are not prepared for life after foster care.

When foster youth in group homes are not provided with opportunities to connect with potential adoptive families or prepare for life after care, they are at risk for aging out of foster care with very limited resources. The longer a child is in congregate care, the more likely they are to experience the negative outcomes of congregate care. Without family or caring adult there to advocate for them, foster youth may find themselves spending an unnecessary amount of time in congregate care facilities. If allowed to stay in congregate care until their 18th birthday, many foster youth may age out of the system without a family. In 2006, 26,181 youth aged out of care in the United States. "On average, youth who aged out of foster care in 2006 spent 5 years in the system, compared with less than 2 years for children who left through reunification, adoption, guardianship or other means," (The Pew Charitable Trusts, 2008).

According to Freundlich (2003), there are a number of negative outcomes for children who age-out of foster care: They often need highly intensive and specialized mental health services but do not know where to receive them, they tend to be at an educational disadvantage, appear to face unemployment and underemployment in significant numbers, are at high risk of poverty, are at risk of victimization, are likely to be arrested or spend time in jail, and often face homelessness.

Current Measures to Address the Problem Need Improvement

To address the problem of children lingering in foster care, policies were put into place to follow up on a regular basis and be sure that permanency goals were being pursued for foster children. The Social Security Act first developed "dispositional hearings" where county case workers were forced to document "reasonable efforts" to find a permanent family for children in foster care. The dispositional hearings were to be held no longer than 12 months after the child entered foster care and then every 12 months after that.

According to the Children's Bureau, the first purpose of a dispositional hearing is to develop a permanency plan. The Permanency plan could include goals of: return to parent, termination of parental rights and then adoption, legal guardianship, placement with a fit and willing relative, or placed in another planned permanent living arrangement. After a permanency plan is established, additional disposi-

tional hearings would ensure that reasonable efforts were made to place the child in a timely manner in accordance with their permanency plan.

An update to the Social Security Act, The Adoption and Safe Families Act (Public Law 105–89) was enacted on November 19, 1997. The Adoption and Safe Families Act changed the name of the hearing required from “dispositional” to “permanency.” The Act also changed the requirement for what must be determined in the permanency hearings to emphasize that these hearings must determine a specific permanency plan for a child. This change more clearly defines the purpose of the permanency hearing (Children’s Bureau). The act also included adoption incentive payments to county DSS offices who had an increase in the number of adoptions in their county.

The permanency hearings were further strengthened by Governor Pataki’s 2005 Permanency Bill. The Permanency Bill requires permanency hearings every 6 months, instead of 12, in New York State. Workers in New York are now required to justify what is being done to move a child from foster care to a permanent family setting every 6 months.

Florida’s Guardian Ad Litem Program clearly outlines the federal policy of Permanency Hearings: At the Permanency Hearing the court must determine: (1) whether the current permanency goal for the child is appropriate or should be changed, (2) when the child will achieve one of the permanency goals and (3) whether the department has made reasonable efforts to finalize the permanency plan currently in effect. The following permanency goals are available—listed in the order of preference: (1) Reunification, (2) Adoption, (3) Permanent Guardianship, (4) Permanency Placement with a Fit and Willing Relative or (5) Placement in Another Planned Permanent Living Arrangement (APPLA).

Permanency hearings give the court a chance to mandate that certain actions be followed by the county workers or other agencies involved with the child. The goal of permanency hearings is to prevent children from being in foster care longer than necessary. Ideally, the foster child would also get a chance to make their voice heard and express their satisfaction with movement toward their goal.

This policy was created to meet the agenda of children in foster care, to be sure that their best interest is being pursued. The policy also benefits tax payers and state agencies because it costs the state less to move children out of residential treatment or foster care and into a permanent family.

Critique of Current Measures

Permanency Hearings are an excellent policy, and if used correctly, they could help a child achieve permanency more quickly. However, there are some shortcomings to this policy and somehow, some children continue to linger in congregate care. The first shortcoming is that permanency hearings do not fully address the need to get children who are freed for adoption out of group homes. Caseworkers can continue to ask for extensions to keep children in foster care and they are not pushed to move the children out of congregate care by the court. As long as the county workers can prove that they are continuing to be open to adoptive families while the child is in the group home, the child does not have to be moved. In order for the child to be moved, the county caseworker or the group home staff needs to make the decision that the child is now ready be moved to a lower level of care or a family setting. Many times, the point at which the child is ready to be moved to a family setting is very arbitrary and unclear. It is also somewhat unethical that the people making the decision about whether or not the child is ready to be moved on from the group home are the group home staff themselves who are getting paid every day that the child is in their care.

I propose that each child be represented by a third party who can advocate that they be moved out of group homes or residential treatment facilities as soon as possible. There is already a very successful program called CASA, or Court Appointed Special Advocates, that does just that. CASA are a group of volunteers who advocate on behalf of foster children to see that they do not languish in foster care or group homes. Each child should be appointed a CASA who they meet with on a regular basis and who is well informed of why they are in a group home and what requirements they need to meet in order to be discharged to a family setting.

I also propose that there be a deadline imposed upon congregate care facilities that is enforced by the court during permanency hearings. Most group homes and residential treatment facilities have an average length of time for treatment. I propose that once a child is treated for the decided length of time, be it 8 months or

even 1 year, they are automatically given the chance to prove themselves in a family setting, despite their behavior. I do not feel that behaviors should determine their ability to move to a lower level of care or a family setting. After a certain amount of time, I believe that the group home has done all they can to “treat” a child and the child should be allowed to move on and try living in a family setting once more. The transition should be slow and well planned, giving the child time to adjust to family life once again.

The second shortcoming with the permanency hearings is the goal of Another Planned Permanent Living Arrangement (APPLA). APPLA is a loop hole that allows caseworkers to change a child’s goal and no longer recruit foster or adoptive families. A child may also decide to change their goal to APPLA because they do not believe a family will ever adopt them and they want to “live independently” after they age out of care. However, children are often not given enough education about how difficult it is to live without the support of a family, especially after becoming institutionalized in congregate care settings. Although children should be given the right to choose not to be adopted, they need to be fully educated about what APPLA means and still allowed to live in a foster home or kinship foster home that will better equip them to transition out of care than a residential facility. Caseworkers need to take the time to unpack a child’s resistance to adoption instead of quickly changing their goal to APPLA.

Conclusion

Foster youth must be moved out of congregate care facilities as soon as possible in order to avoid the numerous negative mental health and social outcomes associated with long-term residential treatment and aging out. Policies must be put into place to use Permanency Hearings more effectively so that congregate care placements are strictly monitored. Using Permanency Hearings to keep congregate care facilities in check will help more children be moved into family settings in a timely manner. Policy must make permanency and family connections the first priority for foster children instead of only focusing on treatment in group home settings. If foster children are moved out of congregate care quickly, their mental health will be improved not only in the short term, but they will be less likely to tax the social welfare system as adults who have aged out of foster care.

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First Focus Campaign for Children

“No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes”

Written Testimony for Senate Committee on Finance

United States Senate

May 22, 2015

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Chairman Hatch, Ranking Member Wyden, and members of the Committee, thank you for this opportunity to submit a statement for the record on behalf of the First Focus Campaign for Children, in response to the May 19 hearing titled *“No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes.”* We appreciate the attention that your Committee is bringing to the widely used practice of housing children and youth in the foster care system in restrictive group care settings. As you consider proposals aimed at reducing our overreliance on group homes for children in foster care, we respectfully ask that you consider including the following proposals:

- (1) eliminating the use of federal funds for group home placements for children ages 6 and younger, and requiring additional oversight when congregate care placements are used for older children;
- (2) requiring title IV–E agencies, as a condition of a child’s eligibility, to justify congregate care as the least restrictive foster care placement setting (for children older than 6) through a documented assessment and requiring a judicial finding initially and every 6 months thereafter to confirm that the placement in the congregate facility is the best option for meeting the child’s needs and that the child is progressing towards readiness for a more family-like setting;
- (3) supporting specialized training and compensation for foster parents who provide a therapeutic environment for a child with behavioral and mental health challenges, and allowing for title IV–E reimbursement for the supervision costs for children who may need specialized services during the day;
- (4) time-limiting federal reimbursements for group care to reflect our understanding of the short-term benefits of restrictive placements including residential treatment settings; and
- (5) authorizing the demonstration program outlined in the Administration’s federal fiscal year 2016 budget which would allocate \$750 million to improve federal and state efforts to curb overmedication of children in foster care. As part of this initiative, the Centers for Medicare and Medicaid Services (CMS) would allocate \$500 million as incentives to states that demonstrate reductions in inappropriate prescribing practices and over utilization of psychotropic medications, increased use of psychosocial treatments, and improved outcomes for foster children. These dollars would support state’s efforts to provide effective home and community-based interventions to young people in foster care, reducing the use of residential treatment and other restrictive settings for this population.

The First Focus Campaign for Children is a bipartisan organization advocating for legislative change in Congress to ensure children and families are a priority in federal policy and budget decisions. Our organization is dedicated to the long-term goal of substantially reducing the number of children entering foster care, and working to ensure that our existing system of care protects children and adequately meets the needs of families in the child welfare system. We are especially focused on increasing attention to the health and behavioral health needs of children in the foster care system and identifying policies and practices to effectively address the unique challenges faced by this vulnerable population.

In the past decade, the percentage of children placed in congregate care settings has significantly decreased at a greater rate than the overall foster care population.¹ This trend reflects a growing consensus within the child welfare field that restrictive institutional settings for foster children should be used sparingly, for short periods of time, and only when necessary. With varying success, most states have made efforts to move in that direction and many have seen significant reductions in the number of children in congregate care settings, including New Jersey, Maryland, Maine, Louisiana, and Virginia.^{2,3} In Oregon, Kansas and Maine, the percentage of foster children in congregate care is now as low as 4 to 5 percent.⁴ Several states with above-average percentages of foster children in congregate care are now striving to reduce those numbers.

While these trends suggest that child welfare practice is moving toward more limited use of congregate care, practice is still not consistent across states and more work remains to be done. Several states, including West Virginia, Rhode Island and Colorado, still house more than 25 percent of their foster care populations in group homes.⁵ Shifting away from a reliance on group homes also makes fiscal sense for states, as monthly costs of congregate care can be 6–10 times higher than foster care and 2–3 times higher than treatment foster care.⁶

Admittedly, children who have been abused or neglected often have a range of unique physical and mental health needs, physical disabilities and developmental delays, far greater than other high-risk populations. For instance, foster children are more likely than other children who receive their health care coverage through Medicaid to experience emotional and psychological disorders and have more chronic medical problems. In fact, studies suggest that nearly 60 percent of children in foster care experience a chronic medical condition, and one-quarter suffer from three or more chronic health conditions.^{7,8} Roughly 35 percent have significant oral health problems.⁹ In addition, nearly 70 percent of children in foster care exhibit moderate to severe mental health problems,¹⁰ and 40–60 percent are diagnosed with at least one psychiatric disorder.¹¹

Youth entering group homes often present with multiple complex needs and exhibit behavioral problems. In a nationally representative sample of youth in care, 55% of youth in group care scored in the clinical range of the Child Behavior Checklist delinquency subscale, compared to 48% in non-kin foster care.¹² For youth entering group care, rates of conduct disorder or oppositional defiant disorder diagnoses have also been reported to be as high as 75%¹³—which is significantly higher than the

¹ U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. A National Look at the Use of Congregate Care in Child Welfare. May 13, 2015.

² U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. A National Look at the Use of Congregate Care in Child Welfare. May 13, 2015.

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¹³ Handwerk, M.L., Field, C.E., and Friman, P.C. The iatrogenic effects of group intervention for antisocial youth: Premature extrapolations? *Journal of Behavioral Education*. 2001;10(4): 223–238.

rate reported for youth in foster family settings.¹⁴ While youth placed in group home settings often exhibit behavioral problems, many could benefit from therapeutic mental health services provided in less-restrictive community-based settings rather than group care.

In a recent *Consensus Statement on Group Care for Children and Adolescents*, a panel of internationally recognized researchers in child and adolescent development noted that “children and adolescents have the need and right to grow up in a family with at least one committed, stable, and loving caregiver. In principle, group care (referring to large- and small-scale institutions and group home settings) should never be favored over family care. Group care should be used only when it is the least detrimental alternative, when necessary therapeutic mental health services cannot be delivered in a less restrictive setting.”¹⁵ Even in such instances, group care should end when it is no longer beneficial to the child or youth. Accordingly, placement in group homes should be treated as a time-limited respite or a time-limited therapeutic intervention with defined treatment goals, but not as a long-term place to live.

In practice, children are often placed in group homes because an appropriate foster family or kinship caregiver cannot be found, home-based therapeutic services are not maximized, or in some cases, result from inadequate placement and utilization review processes. In fact, according to a recently published Kids Count policy report, one in seven children in the child welfare system is placed in a group setting even though more than 40 percent of these children have no documented clinical or behavioral need for placement outside a family setting.¹⁶ This practice is especially concerning.

In addition, youth, mostly teenagers, may enter the system because they have developed behavioral challenges that their parents can no longer manage. For these young people, a group home may seem like an appropriate setting given that they appear “difficult to place,” will be reaching an age of majority soon, and should prepare to live independently. The reality is that these young people can still benefit from living in a family, and group placements should not be used as a long-term or permanent placement simply because it is easier to house a child or teen there.

Admittedly, some youth do have complex clinical and behavioral health needs that warrant a short-term stay in a residential treatment facility. In these cases, group placements should serve solely as a short-term intervention and should not be viewed as a destination. Children should only be placed in these settings when clinically indicated and for brief periods of time—no longer than 3 to 6 months—to allow them to receive the therapeutic interventions and services they need. Ultimately, when possible, children should receive treatment and services within their own homes, through services provided in their communities that focus on keeping children with their families.

A number of effective therapeutic alternatives to group homes including Therapeutic Foster Care (TFC), Cognitive-behavioral, family systems and motivational enhancement therapies, Multisystemic therapy (MST), multidimensional treatment foster care (MTFC), and Functional Family Therapy (FFT) are all designed to effectively treat youth within community-based settings. The Surgeon General’s report (1999) highlighted TFC as an effective intervention, noting “youth in therapeutic foster care made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior. In addition, gains were sustained for some time after leaving the therapeutic foster home.”¹⁷ Other studies have also reported on TFC’s effectiveness in preventing violence among youth with a history of chronic delinquency,¹⁸

¹⁴McMillen, J.C., Zima, B.T., Scott, L.D., Jr., Auslander, W.F., Munson, M.R., Ollie, M.T., and Spitznagel, E.L. Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2005;44(1):88–96. [PubMed]

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as well as improvements in behavior, lower rates of institutionalization and also, lower costs as compared to other types of residential care.¹⁹ Additionally, MST has been adapted for juvenile sexual offenders and found to be effective in reducing sexual behavior problems, delinquency, substance use, externalizing problems and out of home placements.^{20, 21} MTFC has also been found to be an effective community-based treatment for chronic, serious juvenile offenders. In comparison to youth receiving group care interventions, youth who received MTFC were found to have higher treatment completion rates, lower recidivism and fewer subsequent days in detention centers.²² Also, FFT is a type of family therapy provided for 3 to 5 months in a clinic or home and has been proven successful in decreasing violence, drug abuse, conduct disorder and family conflict.²³

As Dozier and colleagues (2014) note in the aforementioned *Consensus Statement on Group Care for Children and Adolescents*, “although there are indications in which psychiatric hospitalizations or locked care facilities may be necessary for safety, most serious problems can be treated effectively with community-based interventions.” Yet the reality is that availability of such effective home and community-based interventions is limited and states are struggling to increase their capacity to offer such services to children and youth in foster care. **We urge you to consider authorizing a demonstration program outlined in the Administration’s federal fiscal year 2016 budget which would allocate \$750 million to improve federal and state efforts to curb overmedication of children in foster care. As part of the initiative, the Centers for Medicare and Medicaid Services (CMS) would allocate \$500 million as incentives to states that demonstrate reductions in inappropriate prescribing practices and over utilization of psychotropic medications, increased use of psychosocial treatments, and improved outcomes for foster children.** These dollars would support states’ efforts to provide effective evidence-based or evidence-informed home and community-based interventions to young people in foster care, reducing the use of residential treatment and other restrictive settings for this population.

There is general agreement that group care, and specifically residential treatment, should be viewed as a necessary part of a continuum of interventions. Recognizing that there are instances in which such a placement may be a needed intervention, we should ask *when? for whom? and, for how long?*, when determining whether a group home setting should be considered for a young person.

When?

As noted earlier, we believe that group home placements should only be used when a documented mental health diagnosis, medical disability or behavioral problem cannot be adequately and effectively treated with community-based interventions. **We urge you to consider requiring title IV-E agencies as a condition of a child’s title IV-E eligibility to justify congregate care as the least restrictive foster care placement setting through a documented assessment, and further requiring a judicial finding initially and every 6 months thereafter to confirm that the placement in the congregate facility is the best option for meeting the child’s needs and that the child is progressing towards readiness for a more family-like setting.**

Importantly, as part of an effort to reduce our reliance on group homes, it is essential to provide additional targeted training and support for kinship caregivers and foster parents. **The Administration’s 2016 budget proposal would provide**

care for the prevention of violence: a systematic review. *American Journal of Preventive Medicine*, 28 (2S1), 72–90.

¹⁹ Burns, B.J., Hoagwood, K., and Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*, 2, 199–254.

²⁰ Letourneau, E.J., Henggeler, S.W., Borduin, C.M., Schewe, P.A., McCart, M.R., Chapman, J.E., and Saldana, J. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology*, 23, 89–102. doi: 10.1037/a0014352.

²¹ Swenson, C.C., Schaeffer, C.M., Henggeler, S.W., Faldowski, R., and Mayhew, A.M. (2010). Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. *Journal of Family Psychology*, 24, 497–507. doi:10.1037/a0020324.

²² Schaeffer, C.M., Swenson, C.C., Tuerk, E.H., and Henggeler, S.W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse and Neglect*, 37, 596–607. doi:10.1016/j.chiabu.2013.04.004.

²³ Mercer Government Human Services Consulting. (2008). White Paper, Community Alternatives to Psychiatric Residential Treatment Facility Services, Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services.

specialized training and compensation for foster parents who provide a therapeutic environment for a child with behavioral and mental health challenges, and allowing for title IV-E reimbursement for the supervision costs for children who may need specialized services during the day. This proposal reflects a concerted effort to limit the use of congregate care facilities for children in foster care by increasing investments in family-based care for children who have mental, social, or behavioral health needs. It recognizes the importance of building up supports, training and resources for kinship caregivers, foster parents and specialized caregivers. **We urge your support and leadership to ensure passage and adequate funding for these critical improvements outlined in the Administration's FY 2016 budget.**

For Whom?

Children belong in families. For children 12 and younger, it is especially important that their developmental needs are met in a family setting. A number of studies have documented the detrimental effects of group care on young children.²⁴ Knowing that healthy attachments are essential, especially in younger children, those raised in group care settings are vulnerable to disturbances of attachment and development.²⁵ Despite what we know about the devastating impacts of group settings for younger children, nearly a third of children placed in group facilities are younger than 13.²⁶

We believe that young children should not be placed in group home settings, and **strongly urge you to consider disallowing the use of federal funds for group home placements for children younger than 6, and requiring additional oversight when congregate care placements are used for older children**, including those outlined in the Administration's 2016 child welfare budget as follows:

- As noted earlier, if a child older than 6 must be placed in a congregate care facility, Title IV-E agencies should be required to justify congregate care as the least restrictive foster care placement setting through a documented assessment. Additionally, a judicial finding initially and every 6 months thereafter to confirm that the placement in the congregate facility is the best option for meeting the child's needs and that the child is progressing towards readiness for a more family-like setting;
- Providing support for specialized case management using smaller caseloads and specialized training so caseworkers can focus on supporting family-based care specialized casework.

For How Long?

Shorter lengths of stay in group care have been associated with better outcomes for youth.²⁷ Research has shown that youth placed in residential treatment make most of their gains during the first 6 months, and that because of the adverse impacts of extended stays, including a loss of connection to natural supports, long-term residential stays are often not in the best interest of children and youth.²⁸ Other studies have similarly found reductions in at-risk behaviors during the first 6 months of residential programs with benefits waning beyond that point, suggesting that shorter, repeatable periods of stay are more appropriate than longer stays.²⁹ **We urge you to consider time-limiting federal reimbursements for group care to reflect our understanding of the short-term benefits of restrictive placements including residential treatment settings.**

²⁴ Dozier, M., Zeanah, C.H., Wallin, A.R., and Shaffer, C. (2012). Institutional care for young children: Review of literature and policy implications. *Social Issues and Policy Review*, 6, 1–25.

²⁵ Nelson, C.A., Bos, K., Gunnar, M.R., and Sonuga-Barke, E. (2011). The neurobiological toll of early human deprivation. In R.B. McCall, M.H. van IJzendoorn, F. Juffer, C.J. Groark, and V.K. Graza (Eds.), *Children without permanent parents: Research, practice, and policy*. Monographs of the Society for Research in Child Development, 76, 126–127.

²⁶ U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2015).

²⁷ Hoagwood, K. and Cunningham, M. Outcomes of children with emotional disturbance in residential treatment for educational purposes. *Journal of Child and Family Studies*. 1993;1:129–140.

²⁸ Magellan Health Services Children's Task Force (2008). Perspectives on Residential and Community-Based Treatment for Youth and Families. Retrieved from http://www.magellanhealth.com/media/876271/childrens_residential_white_paper_2008.pdf.

²⁹ Hair, H.J. (2005). Outcomes for children and adolescents after residential treatment: A review of the research from 1993 to 2003. *Journal of Child and Family Studies*, 14(4), 551–575.

Again, recognizing that group care is part of a continuum of interventions, it is important to emphasize that effective residential treatment programs include several key components³⁰ such as:

- individualized treatment planning;
- use of evidence-based therapies;
- attending to problems precipitating entry into treatment;
- intensive family involvement;
- commitment to monitoring outcomes; and
- strong focus on discharge planning and reintegration back into the community.

Among the family services that should be provided to ensure that a young person's relationships are maintained and families are engaged are:

- regular visitation;
- sibling therapy;
- referrals to parenting assessments and bonding assessments; and
- case management to promote regular contact and continuity of care.

With respect to reintegration after treatment, it is critical that post-treatment services are identified within the community. This means ensuring supports such as a case manager, therapist, psychiatrist and mentor services. It is also important that as part of a plan for reintegration into the community, efforts are made to locate a specialized foster home or find relatives that would be an appropriate step-down placement for the child. Additionally, meetings should take place to map out this transition for a young person. Ultimately, permanency work should be prioritized while the child is in group care and the goal should be to safely and quickly transition children to families.

Lastly, in order to reduce our reliance on group home placements, we need to concentrate efforts on:

- finding family placements and foster families for children with complex needs;
- training and supporting parents and caregivers effectively;
- designing and implementing more flexible and trauma informed treatments to meet the needs of these children;
- systematically evaluating congregate care settings;
- implementing evidence-based and evidence-informed interventions and engaging state leadership in developing such community-based programs to meet the needs of children and youth;
- working with congregate care providers to shift programs toward more community-based services;
- developing partnerships and interventions with other systems within communities to care for this population;
- training caseworkers to ensure our workforce is highly skilled and clinically informed to work with all children, especially children who may be at risk of entering congregate care;
- creating thorough assessment and review processes in the care of children with complex needs; and
- ensuring states are monitoring congregate care facilities through their licensing departments and their contract review processes.

We thank you again for the opportunity to submit this statement for the record and look forward to working with you to ensure that children are not unnecessarily placed in restrictive settings and in the care of families whenever possible. It's never too late for a family and our mission should be to ensure that every child in the child welfare system can benefit from a permanent supportive relationship with a caregiver.

³⁰Leichtman, M., Leichtman, M.L., Barber, C.C., and Neese, D.T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry*, 71 (2), 227–235.

Should there be any questions regarding this statement, please contact Shadi Houshyar, Vice President for Child Welfare Policy at shadih@firstfocus.org or (202) 657-0678.

Generations United
Donna Butts, Executive Director

“No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes”

Tuesday, May 19, 2015, 10:00 AM

Generations United is pleased to submit written testimony to the Senate Committee on Finance. We applaud Chairman Hatch, Ranking Member Wyden, and Senator Grassley, among others, for their leadership to improve foster care, to foster family connections, and to prevent sex trafficking of youth in foster care. We further applaud this hearing and the acknowledgment that the foster care system relies too heavily on group placements. According to the latest report from the Annie E. Casey Foundation, one in seven children under the care of the child welfare system is placed in a group setting.¹ More than 40 percent of these children do not have a documented behavioral or clinical need that would warrant placing them outside a family.² These comments focus on kinship care as the best way to safely reduce reliance on foster care group homes.

Generations United is the national membership organization focused solely on improving the lives of children, youth, and older people through intergenerational strategies, programs, and public policies. Since 1986, Generations United has been the catalyst for policies and practices stimulating cooperation and collaboration among generations. We believe that we can only be successful in the face of our complex future if generational diversity is regarded as a national asset and fully leveraged. For almost 20 years, Generations United's National Center on Grandfamilies has been a leading voice for issues affecting families headed by grandparents or other relatives.

Children fare well with relatives

Research shows that children do best in families. Common sense also dictates that children do best with families, because children age out of a system, they don't age out of a family. Among family settings, as federal law has provided since 1996,³ relatives should be the first placement choice.

Research affirms that Congress is right to consider relatives first, because placement with relatives:

- **Reinforces safety, stability, well-being**
- **Reduces trauma**
- **Reinforces child's sense of identity**
- **Helps keep siblings together**
- **Honors family and cultural ties**
- **Expands permanency options**
- **Can reduce racial disproportionality**⁴

Kinship care as a way to reduce reliance on group homes for those already in the foster care system

¹ Annie E. Casey Foundation. (2015). *Every kid needs a family: giving children in the child welfare system the best chance for success*. Retrieved from <http://www.aecf.org/resources/every-kid-needs-a-family/>.

² Ibid.

³ 42 U.S.C. 671(a)(19).

⁴ Center for Law and Social Policy. (2007). *Is Kinship Care Good for Kids?* <http://www.clasp.org/resources-and-publications/files/0347.pdf>; Generations United. (2007). *Time for reform: support relatives in providing foster care and permanent families for children*. Retrieved from <http://www.gu.org/LinkClick.aspx?fileticket=2MRzy-qRhqo%3D&tabid=157&mid=606>; ChildFocus, Inc. (2015). *Children in Kinship Care Experience Improved Placement Stability, Higher Levels of Permanency, and Decreased Behavioral Problems: Findings from the Literature*. Retrieved from

<http://www.grandfamilies.org/Portals/0/Kinship%20Outcomes%20Review%20v4.pdf>.

Over a quarter of the foster care system already relies on relatives to care for children.⁵ Based on the research and how we know children fare, a key way to reduce reliance on group homes is to prioritize and support placements with kin when children cannot remain with the birth parents. Congress has enacted several provisions in the last few years to increase placements with relatives, including mandatory identification and notification of relatives when a child is removed from a parent's care. We applaud these advancements and encourage efforts to further strengthen these provisions and increase the licensing and support of relatives by:

- ***Improving identification and notification of relatives***
- ***Encouraging the use of model licensing standards for family foster homes***
- ***Improving access to comprehensive supports for relatives***

Improving identification and notification of relatives

The Fostering Connections to Success and Increasing Adoptions Act of 2008 requires the states to exercise “due diligence” to identify and notify relatives within 30 days of a child's removal from his/her parent's home. Moreover, the notification requirement includes that the state “explains the options the relative has under Federal, State, and local law to participate in the care and placement of the child, including any options that may be lost by failing to respond to the notice.” 42 U.S.C. §671(a)(29). Anecdotally, when we provide training to states, most audience members seem to know very little about this requirement and do not seem to be providing information concerning options, including foster care.

Generations United recommends changes to help ensure that relatives receive meaningful identification and notification. We recommend that Congress require that the notice to relatives be in writing and include information about additional community resources to help kinship families (other than the child welfare agency); that states define the steps necessary to constitute “due diligence” in identifying and notifying relatives; and that states document their efforts and responses identifying and notifying relatives.

Encouraging the use of model licensing standards for family foster homes

Federal law allows states a great deal of flexibility in creating family foster home licensing standards. The Social Security Act at 42 U.S.C. §671(a)(10) tells states that it must establish and maintain standards for foster family homes and child care institutions that are “reasonably in accord” with recommended standards of national organizations. The problem is that up until now there were no comprehensive national standards. Due to this lack of guidance, licensing standards vary dramatically among the states and often pose unnecessary barriers.

Appropriate relatives are often denied licensure causing children to be placed unnecessarily in group settings or in the limited pool of non-related family foster homes. In other cases, children are placed in unlicensed homes with relatives and consequently receive inadequate supports, which can cause placement instability.

During fall 2014, Generations United, the American Bar Association Center on Children and the Law, The Annie E. Casey Foundation, and the National Association for Regulatory Administration (NARA) released the first set of comprehensive model family foster home licensing standards. NARA, as the nation's association of human service regulators, took the added step of adopting them as its standards.

This model does away with artificial barriers, such as requirements to own vehicles, be no older than age 65, have high school degrees, and live in homes with certain square footage. In their place are reasonable standards that lead to safe and appropriate homes and families. For example, functional literacy is required, rather than high school diplomas, capacity standards are based on home studies, and other methods of transportation, including public transportation, may be used. Generations United recommends that Congress direct states to assess and make any necessary changes to their existing standards, using the NARA model as a tool.

Improving access to comprehensive supports for relatives

In many jurisdictions, even when relatives are licensed foster parents, they are not provided the same level of financial or supportive services as non-relatives. Generations United recommends that Congress require states to designate a kinship care ombudsman or a primary kinship resource liaison at the child welfare agency who provides relatives with information about placement and visitation options, the role

⁵ Generations United. (2014). *The State of Grandfamilies in America: 2014*. <http://www.grandfamilies.org/Portals/0/14-State-of-Grandfamilies-Report-Final.pdf>.

of the child welfare agency in each option, and how each option corresponds to which benefits, resources, and services would be available. This person should help ensure that relatives get access to the same types of comprehensive supports that non-relative foster parents receive, such as therapeutic kinship foster care when children have significant physical and/or mental health issues. The kinship resource person also acts as a liaison with the caseworker assigned to the family, and other agencies and community organizations that provide resources and assistance to relatives.

Kinship care as a way to reduce reliance on group homes by preventing entry into the foster care system

For every one child in foster care with a relative there are about 23 outside the system being raised by a grandparent, other extended family member or close family friend without a parent present.⁶ These families save taxpayers more than \$4 billion each year by preventing these children from entering foster care.⁷ The problem is that these families face unique challenges and need support.

Grandparents or other relatives often take on the care of children with little or no chance to plan in advance. Consequently, they often face obstacles arranging legal custody, addressing the children's education needs, accessing affordable housing, ensuring financial stability, and obtaining adequate health care for the children and themselves. Under current child welfare financing laws, these families do not receive any preventative or supportive services to keep them together and out of foster care.

The best way to reduce reliance on group care is to prevent children from entering foster care in the first place. Support and prevention services for these kinship families can prevent entry into the much more costly foster care system. Allowing states to flexibly use Title IV-E funds under the Social Security Act can prevent children from entering the foster care system, thereby reducing reliance on group homes, ensuring a family for every child, and decreasing the overall number of children in the foster care system.

Thank you for the opportunity to offer written testimony for this important hearing. Please direct questions regarding this testimony to Jaia Peterson Lent, Generations United's Deputy Executive Director, at jlent@gu.org or 202-289-3979 or to Ana Beltran, Generations United's Special Advisor at abeltran@gu.org.

Human Rights Campaign
David Stacy, Government Affairs Director

Statement Submitted for the Record to the

Committee on Finance
United States Senate

No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes
May 19, 2015

Chairman Hatch, Ranking Member Wyden, and Members of the Committee:

My name is David Stacy, and I am the Government Affairs Director for the Human Rights Campaign, America's largest civil rights organization working to achieve lesbian, gay, bisexual and transgender (LGBT) equality. On behalf of our 1.5 million members and supporters nationwide, I am honored to submit this statement into the record for this important hearing on ways to safely reduce reliance on foster care group homes. My comments specifically address ensuring safety, permanency, and well-being for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth in such settings,

While data on the prevalence and experiences of LGBTQ youth in foster care is limited, research to date has demonstrated that LGBTQ youth are over-represented in foster care and they face a greater likelihood of being placed in group home settings. For example, a recent study in Los Angeles conducted by the Williams Institute found that nearly 1 out of 5 (19.1%) LA-based foster youth are LGBTQ and the per-

⁶ Ibid.

⁷ Ibid.

centage of youth in foster care who are LGBTQ is between 1.5 and 2 times that of youth living outside of foster care.¹ This study also found that LGBTQ youth are living in group homes at a much higher rate than their non-LGBTQ peers—25.7% compared to 10.1% respectively.

Many LGBTQ youth enter foster care after experiencing rejection, abuse, and/or neglect by their families of origin *because* of their LGBTQ status. In other words, these youth have been rejected by their families because of an aspect of who they are—their sexual orientation, gender identity, or gender expression. Far too many of these LGBTQ youth then go on to experience further rejection at the hands of incompetent or biased caseworkers, social workers, foster parents, and staff or peers in group homes. One youth in care explained the severity of this problem when he described his experiences. “I got jumped by a bunch of guys in my group home, and when I told the director, he said, ‘Well, if you weren’t a faggot, they wouldn’t beat you up.’”² A survey of LGBTQ youth in group home settings in New York City found that 100% of these youth experienced verbal harassment related to their LGBTQ status and 70% reported physical violence. Seventy-eight percent had been removed or run away from placements due to LGBTQ-related hostility, and 56% stated they lived on the streets for periods of time because they felt safer there than in their group or foster homes.³ These experiences of hostility within systems of care force many LGBTQ youth to make difficult decisions in order to meet their most basic needs, including engaging in “survival sex” or “couch surfing” that involves sexual exchange.⁴ This can be especially true for transgender youth who are at risk of physical and sexual abuse while in group homes. Mariah, a young transgender woman, explained her experiences of hostility in a group care setting, “I came in to the detention center dressed as I always did, and they ripped the weave out of my hair, broke off my nails, wiped my makeup off, stripped me of my undergarments, and made me wear male undergarments and clothes.”⁵

As these statistics and stories demonstrate, decreasing the child welfare system’s utilization of group homes while simultaneously expanding family- and community-based supports is especially important for ensuring the safety, permanency, and well-being of LGBTQ youth in care.

One part of this work is increasing child welfare agencies’ capacity to recruit, train, and retain LGBTQ-affirming foster parents. LGBTQ youth are often placed in group home settings because there is a lack of potential foster home placements for these youth.⁶ Even the most LGBTQ-inclusive agencies can struggle to find qualified foster parents who are ready and willing to welcome LGBTQ youth into their homes. Child welfare agencies must actively assess the readiness of current foster parents to affirm LGBTQ youth and include LGBTQ issues in foster parent training. Recognizing that LGBTQ adults are one potential group that could provide affirming foster homes for LGBTQ youth, agencies should engage LGBTQ adults who may be interested in becoming foster parents.

As stressed by several of the others submitting testimony today, effective prevention services that address the needs of children and families early is another important part of the solution. For LGBTQ youth and their families, this means ensuring that agency intake and family preservation case workers have the training and skills necessary to assess whether a young person’s sexual orientation, gender identity, or gender expression is a factor in a family’s involvement with the system. Once this

¹ Wilson, B.D.M., Cooper, K., Kastansis, A., and Nezhad, S. (2014). Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles: The Williams Institute, UCLA School of Law. Available at

http://williamsinstitute.law.ucla.edu/wp-content/uploads/LAFYS_report_final-aug-2014.pdf.

² <https://www.lamdalegal.org/sites/default/files/publications/downloads/out-of-the-margin-s.pdf>.

³ Feinstein, Randi et al. Justice for All? A Report on Lesbian, Gay, Bisexual and Transgendered Youth in the New York Juvenile Justice System. (New York City: Urban Justice Center, 2001).

⁴ NYCAHSIYO (New York City Association of Homeless and Street-Involved Youth Organizations). 2012. State of the City’s Homeless Youth Report 2011. New York: NYCAHSIYO. As cited in: Urban Institute (2015). Surviving the Streets of New York: Experiences of LGBTQ Youth, YMSM, and YWSW Engaged in Survival Sex. Available at <http://www.urban.org/sites/default/files/al fresco/publication-pdfs/2000119-Surviving-the-Streets-of-New-York.pdf>.

⁵ Marksamer, J. (2011). A Place of Respect: A Guide for Group Care Facilities Serving Transgender and Gender Non-Conforming Youth. National Center for Lesbian Rights and Sylvia Rivera Project. Retrieved from <http://www.nclrights.org/wpcontent/uploads/2013/07/A Place of Respect.pdf>.

⁶ Jacobs, J. and Freundlich, M. (2006). Achieving Permanency for LGBTQ Youth. Child Welfare, 85(2), 299–316.

is identified, these workers should provide family-based services utilizing best practice resources, such as SAMHSA's "A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children." Research shows that when given the appropriate education and support, families can shift from behaviors of rejection to acceptance toward their LGBTQ children.⁷ And this shift, even if small, can have an immediate and significant positive impact on that child's well-being.

Policy solutions to improving outcomes for LGBTQ youth in group homes and other out-of-home care settings are necessary on the federal and state levels.

- Congress should protect LGBTQ youth from discrimination by passing legislation prohibiting discrimination based on sexual orientation and gender identity by recipients of federal funds, including foster care group homes receiving funding under title IV-E of the Social Security Act.
- The Administration for Children and Families (ACF) should issue separate guidance clarifying the obligations of state child welfare agencies that receive federal funds, including foster care group homes, to adopt and implement policies prohibiting discrimination based on sexual orientation and gender identity.
- ACF should continue to offer federal financial participation under the title IV-E program for high quality LGBT cultural competency training and technical assistance.
- ACF and state agencies should assess local and state programs as potential models such as those in California, New York, Massachusetts, and Pennsylvania that have implemented LGBTQ nondiscrimination policies, adopted data collection on sexual orientation and gender identity, and mandated associated training or are in the process of doing so.

I appreciate the opportunity to offer this testimony today and urge Congress to act to reduce reliance on foster care group homes to ensure all foster youth, including LGBTQ youth, have the best chance possible to belong to a loving, stable, and affirming family.

Rachel's Tears Ministry

No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes

United States Senate Committee on Finance

Tuesday, May 19, 2015

Statement for the Record prepared by:

Cheri Campbell ~ President and Founder of Rachel's Tears

Submitted in agreement by:

Pastor Joseph Campbell ~ Senior Pastor ~ Church of Morongo

50865 29 Palms Hwy.

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Introduction

Thank you for the opportunity to have some impact on achieving better outcomes for children and their families. Front loading funding to 80% Family Preservation and 20% department services will provide immediate relief for the greater good of society and, at the same time, be extremely cost-effective.

This preventative measure eliminates the need for more group or foster homes and it protects children from the greater risk of abuse, neglect and/or death from substitute placements. The unending request for more money, by CPS and related serv-

⁷Ryan, C., Huebner, D., Diaz, R., and Sanchez, J. (2009). Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. *Pediatrics*, 123, 346–352.

ice providers to solve the problems being discussed, will never alter outcomes for children or their families because the appropriated funds are not properly utilized.

Currently 80% of Federal funding goes to foster care, adoption bonuses and the related services while a child is in State's custody. Only 20% of the funding goes to Biological Family Preservation. This action directly violates the Welfare and Institutions Code 300 Series and the Legislative intent to "protect the child in the least intrusive manner."

The Title IV-E Funding Waiver program (which ended in Dec. 2014) did give some flexibility for the few states that applied for it but does not address the root of this poisonous policy. The main problem is that a child can be removed for minor infractions and unsubstantiated allegations. This easily proceeds to Termination of Parental Rights (TPR) and adoption if the child is considered "adoptable." Parents are then placed in the Child Abuse Central Index (CACI) without Due Process.

CPS non-compliance and lack of moral compass, either by choice or threat, along with Juvenile Court agents appear to be unseemly motivated in protecting federally appropriated funding. By simply redirecting the funding to Family Preservation can spare a child the life-altering trauma of being forcibly removed from their biological family.

Seeking Redress and Remedy

The following observations and solutions are written from a trifold perspective: victim, family advocate and one of many who have spent personal time and treasure trying to alter or abolish the current system.

We have sought remedy from the local level up to the federal level to no avail since January 2003. We attended Congressman Joe Baca's forum in San Bernardino, CA on CPS abuse in March 2004. Please reference: *Statement of Hon Joe Baca, "Government Bureaucrat Abuses in Child Protective Services (DSS) and the 'Legal System'"* (<https://www.gpo.gov/>).

My husband, Pastor Joseph Campbell gave the opening prayer. We were scheduled speakers but time prevented it due to so many out of state speakers. Congressman Baca sent 163 evidence notebooks of CPS abuse under color of law to Washington D.C., was told they would be placed in the Congressional Library for law students to study but they were eventually sent back.

We arranged a meeting with former San Bernardino CPS Director Cathy Cimbalo. During the many pleas for help at San Bernardino County Board of Supervisors, we often heard Ms. Cimbalo "invite the sunshine" so we accepted. My husband taped this meeting and several legislative representatives attended. In response to Pacific Justice Institute's inquiry regarding a conflict of interest by allowing department agents to foster or adopt, Ms. Cimbalo stated "there is none." Listed below are a few examples that rise to the threshold of cruel and unusual punishment and further solidify the need to keep children with their families whenever possible.

(1) *4 year old Logan Marr's death* resulting from her social worker foster mother duct taping her to a high chair in the basement because Logan refused to call her "mom." (<http://www.pbs.org/>)

(2) San Bernardino *Superior Court Judge Kamansky* who gained custody of Jason Wayne Bumpus and then used his position as Bumpus' court appointed guardian to sexually molest him. Jason eventually committed suicide. (<http://law.justia.com/>)

(3) March 31, 2015 Former No. Carolina CPS department *Supervisor Wanda Sue Larson* pled guilty to child abuse charges where officials say the child was found chained to the porch with a chicken tied around his neck in 2013. (<http://www.wsocv.com/>)

I submitted 16 Official Grand Jury Complaints, detailing abuse under color of law, to San Bernardino County on two separate occasions. We were denied a hearing. I then hand-delivered the same Official Complaints to District Attorney Mike Ramos and requested an investigation. We received no answer from his office.

I submitted a *statement for inclusion in the Record of the June 9, 2005 House Committee on Ways and Means*. Congressman Herger was seeking better outcomes for children and Congresswoman Nancy L. Johnson wanted funding front loaded to help keep biological families intact.

My husband and I submitted a packet for the Record of *The Citizens Commission on Human Rights—Inquiry for Violations of Human Rights by Child Protective Services—May 20, 2006 held in San Jose, CA.*

I have gone to the State Capitol two times to address my concerns regarding CPS abuse and met with many Legislators. I spoke with former Georgia Senator Nancy Schaefer several times seeking solutions. She was deeply grieved by the many pleas for help and actively sought remedy on behalf of children and their families. We also spoke about these problems at the CA Performance Review at UCC Riverside sponsored by former Gov. Schwarzenegger who offered no remedy.

We spoke at the rally in Washington, D.C. in 2007. Please listen to our words of hope and encouragement to the families and children that have been so easily torn apart by CPS and Juvenile Court at: dcrally2007.com

Due to the heinous nature of “actual” child abuse or neglect, altering the system by forcing Child Protective Services (CPS) compliance and redirecting funding is the most reasonable solution.

Follow the Money

When funding streams are determined by need for services, or incentivized bonuses for adoption, children can easily be viewed as “chattel or merchandise” by some whose jobs depend on “quantity.” CPS, Juvenile Court judges, public defenders, foster/group homes and all other shareholders receive compensation from the same appropriation based on the number of children in the system.

In 1974 Walter Mondale (with Hillary Clinton’s help) created the *Child Abuse and Prevention Act* which began feeding massive amounts of federal funding to states to set up programs (CPS) to combat child abuse and neglect. After the bill passed, Mondale was rightly concerned that it could be misused to create a “business” in dealing with children.

In 1997 the *Adoption and Safe Families Act* was created due to the massive number of children languishing in foster care. President Clinton’s *Adoption 2002 Initiative* and the adoption law of 1997 created the first-ever financial incentive for states to increase adoptions of children. This created a bounty on our children’s heads and the adoption rate quickly doubled. (Report—Kentucky Youth Advocates) Therefore, using the basic “Follow the Money” principle, the problem is easily identified.

Profound Non-Compliance

Decades of State imposed fines for non-compliance, dozens of recommendations from recognized think tanks and million dollar lawsuits have not adequately altered current patterns and practices of the department. These costly lawsuits have no punitive consequences for those found guilty and offer little remedy for the emotional injuries this Nation’s most vulnerable are forced to endure. A request for the Department of Justice to open a Federal pattern and practice case into CPS abuse under color of law should be forthcoming.

California Judges Benchguide (CAB)100.56 states “court finds preplacement preventive efforts were made to avoid removing child OR Reasonable Efforts were not made” which results in returning the child. The Judicial Tip under the CAB is, “If the child has been removed, it is essential to make the ‘contrary to the child’s welfare finding’ the first time the court considers the case. . . . Failure to make this finding may result in permanent loss of federal funding for foster care.” This provides insight from top to bottom that Federal funding and job security trumps the child’s 4th and 14th Amendment rights, Constitutional protections and the child’s best interests.

As we look further into the court process, it is evident that judges are reminded to protect the funding which is only available based on the number of children being processed. CAB 100.24 gives parents the opportunity to provide exculpatory evidence but it’s very difficult to get it on the record and the hearing is only a few minutes long. EXAMPLE: Just before our Contested Hearing in 2003, our attorneys took us aside and told us, “If you continue with this hearing, ‘they’ will separate your grandchildren, adopt them out and you’ll never see them again!” After years of confronting each of them, they both admitted to me that “County Counsel Patty Campbell told them to tell us that.” Threat, duress and coercion are very effective ways to stop fundamental Due Process.

Additional Solutions

- No child shall be removed prior to Reasonable Efforts and Preplacement Efforts actually being made to prevent removal unless the child is in Exigent circumstances which must be substantiated with evidence
- Video tape all removals to prevent false statements
- Case plans shall not be made until allegations are substantiated with evidence
- The accused must be allowed to confront the accuser
- False and malicious calls must have punitive consequences
- Open Juvenile Court to ensure Due Process rights
- Attorneys must zealously defend our basic and God given inalienable rights, including familial integrity
- Presumption of guilt must be eliminated
- Due Process must be upheld before being placed in CACI
- Punitive consequences must be made for inaccurate social worker's reports signed under penalty of perjury
- Lawsuits against the department or its agents shall be paid by the defendant(s) not from State coffers
- Whistleblowers must be protected

Conclusion

Negative results of current patterns and practices used to “protect children” are easily identified in higher drop out rates and academic loss (State Impact). This negative impact is also noted in undesirable outcomes for children aging out of the system and in over-populated prisons (Alliance). Therefore, it is imperative to provide every protection available for the child and their biological family. This includes fundamental Due Process before the current cruel and unusual punishments are imposed upon familial integrity. Reasonable use of Preventive measures must be applied before a child is removed.

We must remove the cloak of secrecy behind which CPS currently operates, open Juvenile Courts and fire bad actors to effectively stop unnecessary removals. As the 19th century British historian, statesman and philosopher John Emerich Edward Dalberg-Acton eloquently proclaimed, “Everything secret degenerates, even the administration of justice: nothing is safe that does not show how it can bear discussion and publicity.”

These cost-effective solutions are easily implemented. They will curtail the department's ability to pervert the Legislative intent, designed to protect children, into frameworks for crimes against humanity. We must remain steadfast in the best solution to achieve better outcomes for children, and that is to prevent them from entering foster care at all.

The ruin of a Nation begins with the destruction of its family units and injustice creates seeds of distrust. This opportunity for redress will bring some remedy to those already victimized and it will prevent future meaningful, committed family life from being unnecessarily disrupted.

May Wisdom be granted as solutions are considered for better outcomes for children and the greater society.

Sincerely,

Cheri Campbell

Joseph F. Campbell

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No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes

Written Testimony for the Senate Committee on Finance

United States Senate

May 22, 2015

Chairman Hatch, Ranking Member Wyden, and Members of the Senate Committee on Finance:

While we have more than six decades of combined professional experience in child welfare practice, policy and research, we submit the following testimony to you today primarily as the adoptive parents of two children with prenatal substance—exposure based on our perspectives in caring for them over the past 21 years.

From our experiences, and the challenges and successes they have brought, we are convinced that first-rate residential care is an essential part of a healthy continuum of care in the child welfare and mental health systems. When a child is properly assessed and the residential setting is targeted to meet a child's specific needs, it can make a critical and often lifesaving difference for children and families as they face critical challenges in their lives.

As parents and as policy and research professionals working at the intersection of the child welfare, mental health and substance abuse systems, we have seen both the best and worst of residential care. We have seen our children, both of whom have experienced mental health and substance abuse challenges, cared for in some excellent agencies and helped by excellent therapists who have equipped them with the skills they need to return to us and become productive members of their communities. At the same time, we have also experienced some of the extraordinary incompetence and the bewildering programmatic and financial thickets that parents must endure and navigate on behalf of their children. We have concluded that first-rate group care can exist and does exist—and that it must continue to exist as an option for a segment of children and youth at critical points in their development. However, it should be balanced with the public policy that supports birth families to prevent placement and discourages poor group homes that are used as a default placement for children who could otherwise return home, be cared for by loving family members, or be placed in supportive foster families with the right training and support to meet their needs.

In framing our response to recent Congressional proposals to decrease the over-reliance on group care, we agree with the Members of the Committee that the fundamental starting point should be that *all children should grow up in families, not institutions*. At present, it is undeniable that, in making choices about how to best care for children and youth in the child welfare system, group homes are too often used as a default placement. We have witnessed first hand that some child welfare systems find it easier to rely on group care instead of providing parents with the prevention and treatment supports needed to keep families together, support kin, and recruit and support quality foster families. In the longer run, however, congregate care that is not customized to meet the short-term needs of the child and that do not have the ingredients of excellence may end up costing the system more and, even more tragic, miss the opportunity to make a positive difference in the lives of children and families dealing with serious challenges.

At the same time, however, recent policy discussions at the federal level have made too little distinction between poorly regulated and overused group homes that warehouse young people and the alternative: therapeutic settings that provide substance use and mental health services needed to stabilize some children so they can return to their families and communities.

High-quality group care does exist. The quality and appropriateness of these settings depend on whether providers and staff understand the requisite ingredients of group care for those children who need structure and therapy, who have suffered high levels of abuse, neglect, and trauma and, in many cases, prenatal exposure to drugs and alcohol that have left them in need of more than family-based care can provide at critical junctures in their development. While Federal policy can discourage the inappropriate use of congregate care, we must ensure that it does not swing too far away from providing appropriate residential care when children need treatment and an opportunity to heal. Just as residential care cannot be used to raise children when they would be better off in families, we cannot pretend that the families of children who are facing serious challenges such as those stemming from prenatal alcohol exposure, their own substance abuse or serious mental health problems are adequately equipped to care for and protect them when what they really need is a structured environment and the treatment of highly skilled professionals. While we support strategies that would eliminate the over-reliance on inappropriate non-therapeutic group homes, we want to make sure that these would not adversely impact young people's access to the substance use and mental health treatment they need to achieve recovery, address trauma and other mental health issues.

Ironically, it is often the inability of systems to match young people and their families with the right treatment when they first come to the attention of the child welfare or mental health systems that makes them more even vulnerable to placement in poor quality group homes over time. When children and their parents do not get the right help from the beginning, problems can easily and quickly turn into a crisis that families simply do not have the expertise to handle. In too many cases due to funding and treatment access complexities, these families have no choice but to rely on the child welfare system to secure the care that they need for their child.

Moreover, many foster and adoptive families lack the information about the full extent of the harm done to children they are seeking to care for which makes their task as caretakers a series of unexpected shocks for which they are often ill-prepared. A recent review of adoptive parent training and orientation, both pre-adoption and post-adoption, indicated that the few fine models that exist to adequately prepare adoptive, foster and kinship families to care for children serve far too few parents and children. As a result, this lack of parental preparation and understanding, particularly regarding the impact of prenatal alcohol exposure on cognitive and behavioral effects, can leave children even more likely to end up in group care as a last desperate, end-of-the-line placement.

Whatever incentives are suggested in legislation to reduce or eliminate inappropriate group care settings must also be careful to ensure that young people have full access to residential treatment options when they are clinically appropriate and, moreover, that funding is also available to support the continuum of services that prevent children from coming into the system in the first place. In addition, post-permanency services should include specialized substance abuse training and supports for parents, kin and foster families who are caring for a young person in recovery once the young person returns home and community-based services to help the young person maintain sobriety.

As other witnesses testified in the May 22 hearing, the trajectory of substance abuse and mental health treatment can often be difficult to predict. Research shows that, particularly with addiction, recovery timelines differ significantly based on individual circumstances and that relapse is often part of the recovery process—a reality that may necessitate multiple stays in residential treatment over the course of a young person's lifetime and during their time in foster care. Limitations on group care must never interfere with a young person's access to needed treatment, especially when that support makes a critical and even life-saving difference in an individual—and a family's—current and future stability.

We understand that creating a balanced federal policy is difficult. We also recognize that different funding streams come under the jurisdiction of different Congressional Committees and federal agencies. Despite these realities, however, we are particularly interested in better coordination between federal child welfare, Medicaid and private insurers to ensure that youth receive the full range of substance abuse and mental health treatments that they need to recover. In too many cases, limited child

welfare funding is used to pay for clinical interventions that Medicaid and private insurers under parity requirements should already be covering. This supplanting of funds takes valuable dollars away from other necessary interventions that do not have alternative funding streams to support them and, as a result, are not made available to the families who need them. Child welfare systems should not be held solely accountable for addressing the costs and services needed by the most severely affected children—especially during the largest potential expansion of funding available for treatment of mental and substance use disorders.

We would also urge those reviewing these policies to access the excellent video recently produced by Ira Chasnoff and his colleagues at NTI Upstream. Entitled *Moment to Moment*, the documentary chronicles the stories of three sets of prenatally exposed youth, carefully focusing on the family and institutionally based care that these youth experienced. The video shows both how the most severely affected of these children need a genuine alternative to family-based care and how, at the same time, families play a fundamental and ongoing role in their children's recovery and well-being.

In closing, we would like to share with the Committee that we also approach this issue as policy researchers who have spent most of the past 20 years working at the intersection of child welfare and substance abuse issues, familiar with both the data and the program models in this field. From that experience, we are convinced that a critical segment of children and youth need effective institutional care for at least a portion of their lives. We also have come to believe that institutions exist and can be replicated that are not warehouses, but caring places in the best traditions of social work and with the commitment to working with families to return children to their homes and communities once they have received the specialized treatment and care they need.

We thank you again for the opportunity to submit this statement for the record and look forward to working with the Committee to ensure a balanced approach to the reduction of residential care—one that honors the role of families by providing them with the full range of supports they need to help their children thrive.

Please do not hesitate to contact us with any questions by calling (714) 345-6293 or (714) 402-6085 or emailing us at Nkyoung@aol.com.

